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AMERICAN PODIATRY ASSOCIATION

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AUGUST 27, 28, 29, 30
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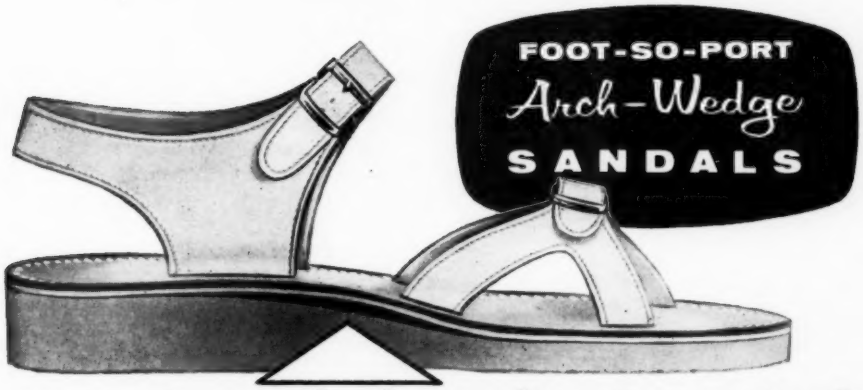

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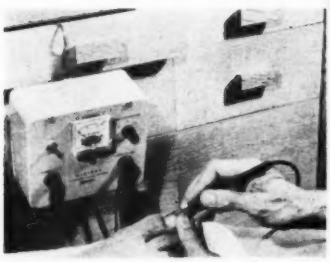

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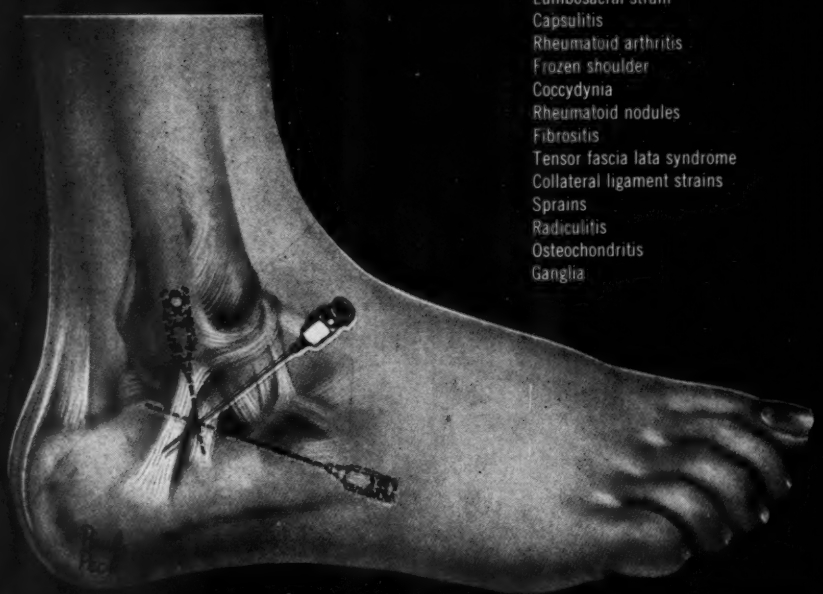

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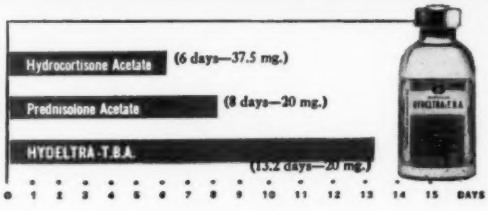
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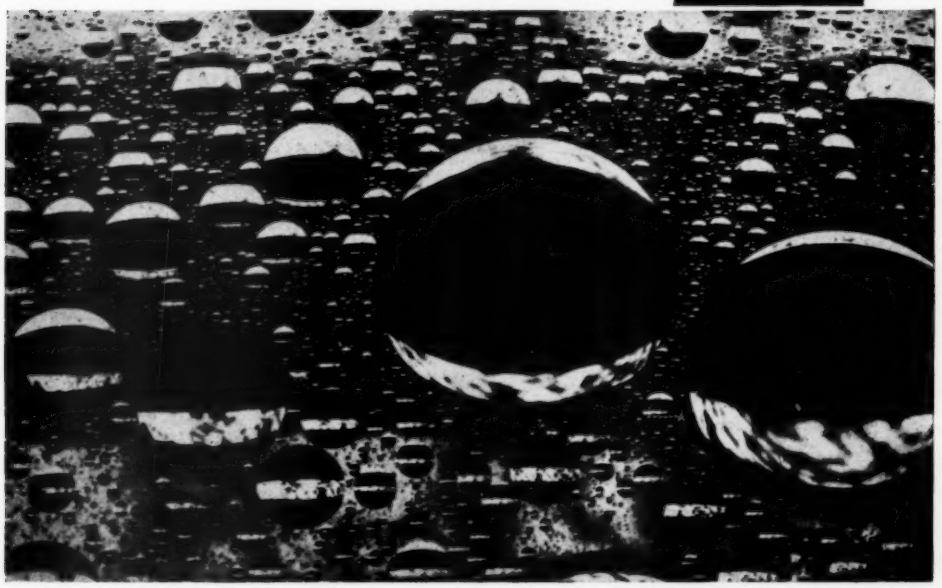

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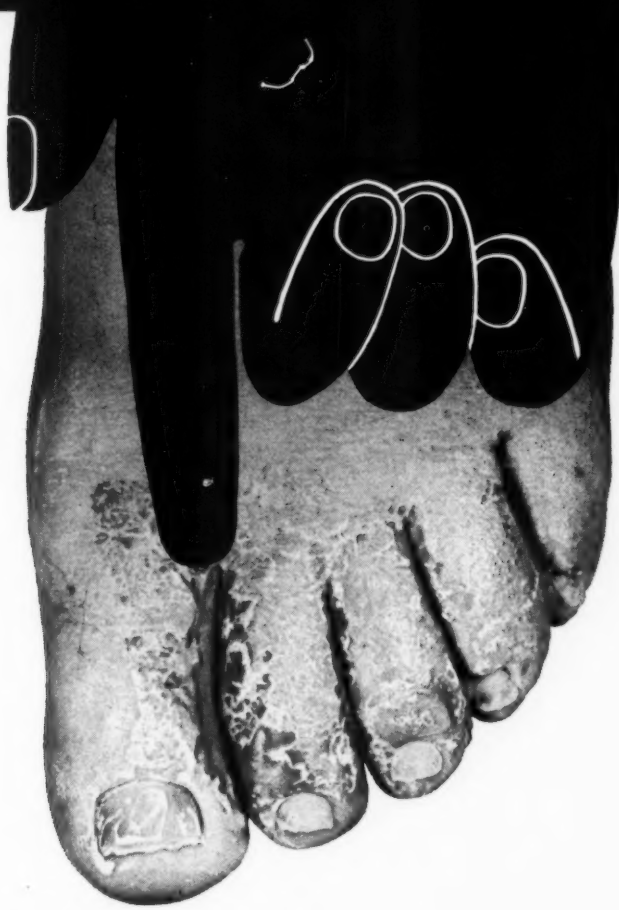

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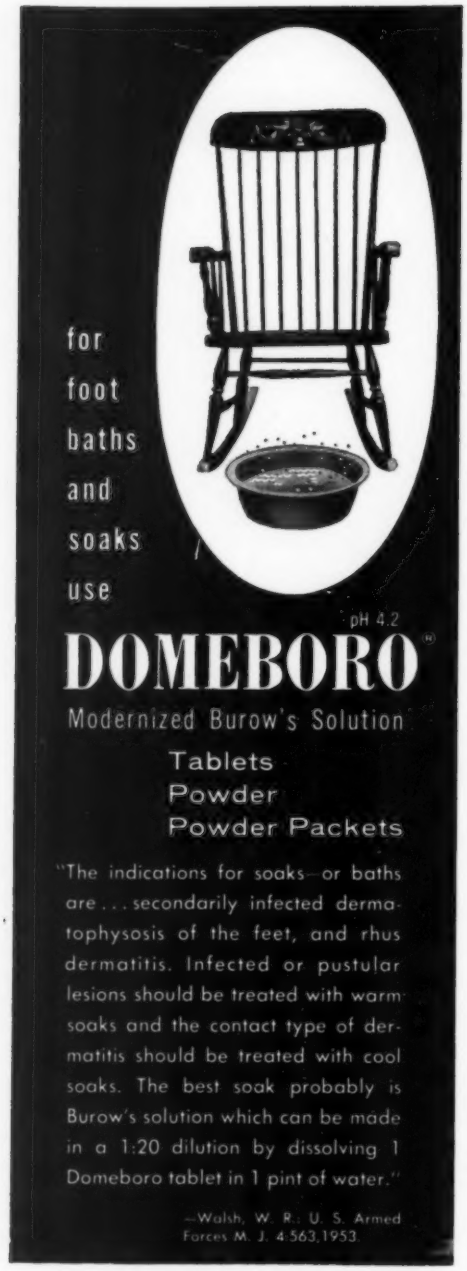
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"The indications for soaks—or baths are . . . secondarily infected dermatophysosis of the feet, and rhus dermatitis. Infected or pustular lesions should be treated with warm soaks and the contact type of dermatitis should be treated with cool soaks. The best soak probably is Burow's solution which can be made in a 1:20 dilution by dissolving 1 Domeboro tablet in 1 pint of water."
—Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953.

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STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama

The Alabama Medical Board of Examiners. **Board Secretary:**

Arizona

The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Arizona.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively in Los Angeles, Aug. 22-25, 1960; in San Francisco, June 20-23; and in Sacramento, Oct. 17-20, 1960. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody will meet for examination July 12-13, 1960 at the State Capitol, Hartford, Conn. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually in January and in July. **Board Secretary:** Harry L. Hoffman, Ph. G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners will meet for reciprocity and examination in June each year, at the discretion of the Board. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee will meet for reciprocity July 22, 1960, and examinations July 22-24, 1960, at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Fredric B. Seicke, Room 109, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners will meet for examination in the State Office Building, Des Moines, June 13-15, 1960. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners will meet for examination and reciprocity at the Kansas University Medical Center, Kansas City, Kansas, June 1960. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.

Louisiana

Louisiana State Board of Medical Examiners will meet for examination June 9-11, 1960 at the Hibernia Bank Bldg., New Orleans, La. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Walter J. Jeffery, 1950 Madison Ave., S.E., Grand Rapids, Michigan.

Minnesota

The Minnesota Board of Chiropody Examiners will meet for examination June 16-17, 1960. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody will meet for reciprocity and examination at the State Capitol Bldg., Lincoln, Nebr., July 1960. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry will meet for reciprocity and examination, July 16, 17, 1960, in Albuquerque. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners will meet for examination, June 28 to July 1, 1960, in New York City, Albany, Syracuse, Buffalo and Rochester. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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"Dermatitis, if present was always treated by simple, nonirritating, local therapy consisting of Domeboro (1/20) wet dressings. These proved vastly superior to any other type of treatment. Subsequent treatment with Daxalan (Ointment) and the Dome boot (Dome-Paste Bandage) sufficed to cure the ulcer."
—Cooper, W. M., Am. J. Surg. 65:475, 1948.

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STATE BOARD *(Cont.)*

North Carolina
The North Carolina State Board of Chiropody Examiners will meet for examination, June 24, 1960, at the Robert E. Lee Hotel, Winston-Salem, N. C. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio
The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma
The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon
Oregon State Chropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 1400 S.W. Fifth Ave., Portland, Ore.

Pennsylvania
Pennsylvania State Board of Chiropody Examiners will meet for examination July 20-21, 1960 at the Education Bldg., Harrisburg, Pa. **Board Chairman:** Dr. Ralph H. Orr, 424 Colorado Drive, Erie, Pa. **Board Secretary:** Dr. Jack S. Pincus, Box 911, Harrisburg, Pa.

Rhode Island
The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina
The South Carolina Board of Chiropody Examiners. **Board Secretary:** Dr. Charles W. Clark, 535 Harden St., Five Points, Columbia, South Carolina.

South Dakota
The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee
The Tennessee Board of Registration in Chiropody will meet for examination August 1, 1960, in Nashville, Tenn. **Board Secretary:** Ronald E. Fields, 524 Bennie Dillon Bldg., Nashville 3, Tenn.

Texas
The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah
The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont
Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia
Virginia Board of Medical Examiners. **Board Secretary:** Kenneth D. Graves, M.D., 631 First St., S.W., Roanoke, Va.

Washington
The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July, in Seattle. **Board Secretary:** Thomas A. Carter, Department of Licenses, Olympia, Wash.

West Virginia
Medical Licensing Board of West Virginia will meet for examination. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin
The Wisconsin State Board of Examiners. **Board Secretary:** O. J. Trimborn, D.S.C., 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Wyoming
The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

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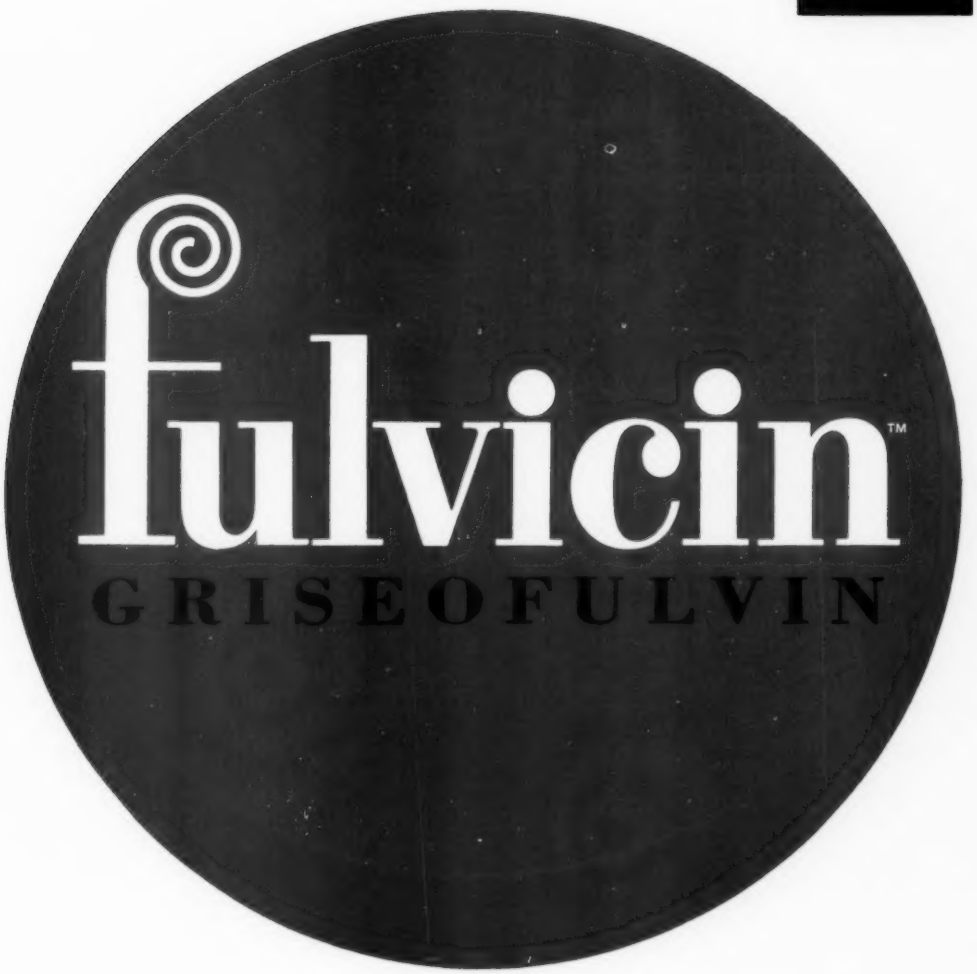

clears ringworm orally **regardless of duration or previous resistance to treatment**

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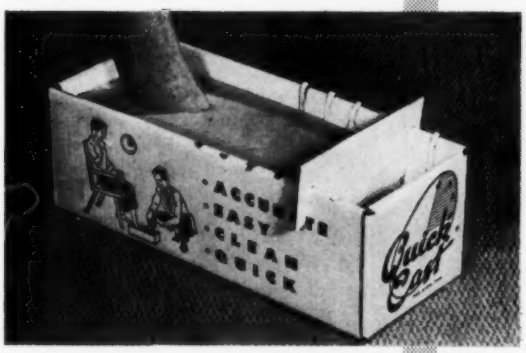

the result – the finest and most comfortable contour shoes your patients can wear

After extensive research, a new, accurate molding technique for contour shoes has been perfected. QUICK-CAST®, using a gelatinous mold completely safe to the skin, is easily performed in 15 minutes. It is neat, accurate and eliminates the heat radiation of conventional plaster which could be dangerous to diabetics.

PERSONAL CONTOUR SHOES are made from this exact casting technique. Available for men and women in six styles and 20 handsome colors. They are custom-crafted of the world's finest leathers. Personal Contour Shoes are long-wearing . . . guaranteed to fit perfectly.

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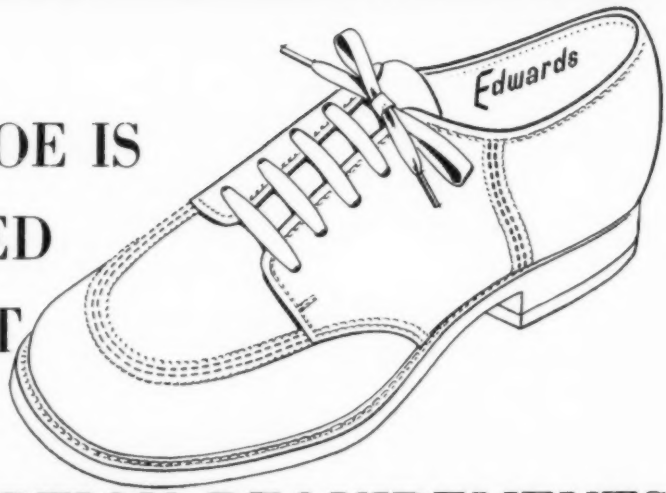

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For maximum adaptability in a *quality* shoe, examine **Edwards** CorecTreds. Long molded inside counters, steel shanks built into the soles, and special lasts for ample tread and toe room give CorecTreds the value distinction typical of *every* **Edwards** shoe.

Mild or extreme pronation, supination, pigeon-toe, or pre- or post-operative needs — *whatever* your prescription, there's an **Edwards** shoe to meet its requirements.

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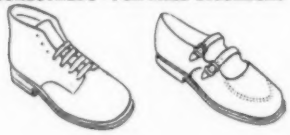

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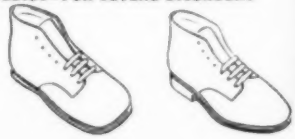

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EDWARDS NEW PEDIC KIT

Now, receive Edwards new, complete Pedic Kit designed especially for you. It contains:

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Simply Detach This Portion of Advertisement, Mail With Your Personal Letterhead to Edwards Shoes, 314 N. 12th St., Phila. 7, Pa.

DAY DATE

90% of the patients you see each day ~~suffer from~~ conditions for which **Podiacort** is a specific!

TIME	NAME	OFFICE DATA
9:00	Raoul rickson	Varicose eczema
9:30	Theo M in	Trophic ulcer
10:00	Raymon tler	Fit corrective brace
10:30	Harriet son	Inflamed nail grooves
11:00	Elmer Sp	Shoe dermatitis
11:30	Ed Dunn	Callus
12:00	P.M.	
1:30	James Tayl	Toe edema
2:00	Allen Jacks	Routine examination
2:30	Edith Ramont	Varicose ulcer
3:00	Rita Wilbourn	Stasis dermatitis
3:30	Jess Sweem	Allergic eczema
4:00	Myrtle Halley	Corn removal & post-op care
4:30	Adolph Lanci	Open wound
5:00	Mildred Casteel	Contact dermatitis
5:30		
6:30	Gabriel Insalaco	Fissures
7:00	Ernst Leva	Infected callosity
7:30	William Waits	Toe bruise
8:00	Filip Rasmussen	Athlete's Foot
8:30	Carol Johnson	Infection(secondary) to ingrown toenail
9:00		

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Good Morning, Doctor,

Pain, inflammation, bacterial and fungus infections, or their possibility, are either the primary or secondary problems with almost all the conditions you see every day in your practice. Unfortunately, as you are only too well aware, your patients seldom appear early enough for effective preventive treatment. Usually, the condition you see has actually developed into a painful or crippling disorder before the patient seeks professional help. By the time they visit your office, one, two, or all four of these complications are present or are threatening.

The patient, in turning to you, wants and needs relief from inflammation and pain, since these two complaints are present in varying degrees in almost all foot conditions. He seeks fast relief without side effects, complicated procedures, or further discomfort.

You must have, in addition to subjective symptomatic relief, positive control of bacterial and fungal infection (where it is already present), as well as protection against any possible infection between visits.

You are constantly faced with the problem of your patient's personal hygiene and, additionally, the very real problem of maintaining an aseptic area in the face of potential foci of infection such as shoes, socks, bed clothes, etc.

Only Podiacort offers you the worry-free answer to these important therapeutic problems.

Exclusively yours,

J. F. Gorman

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jfg:mm
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Announcing . . .

A new and uniquely effective topical agent

from the research laboratories of Podiatrex, Ltd . . .

Podiacort Ointment is a potent anti-inflammatory/antibacterial/antifungal agent for use in a wide range of common foot conditions.

Podiacort Ointment is a formulation specifically developed for you — to help you gain effective control of the majority of conditions you see every day in your office. Podiacort is unsurpassed for definitive control of inflammation and pain, and both bacterial and fungal infection, whether present or threatened.

Podiacort Ointment Offers . . .

Podiacort* (Podiatrex, Ltd. brand of hydrocortisone diethylaminoacetate hydrochloride) . . . a new ester of hydrocortisone with twice the topical anti-inflammatory activity of the most commonly used salts of hydrocortisone.

Podiacort is 400 times more water soluble than the most commonly used salts of hydrocortisone. As a result, Podiacort provides extremely rapid tissue penetration for immediate action at the inflammation site.

Podiacort exhibits a lipophobic, or fat resistant action which affords prolonged anti-inflammatory activity in the affected tissue.[6] [11]

Neomycin Sulfate, effectively combats over 90% of the disease-bearing bacteria found on the skin, the preferred topical antibiotic.[3]

Effective against a wide spectrum of gram-positive and gram-negative pathogenic organisms.

One of the least sensitizing antibiotics known — resistance develops slowly and is never a problem in normal therapeutic use.

Neomycin is seldom used systemically, therefore complications arising from topical application of systemically useful antibacterial agents is avoided.

Undecylenic acid, the time tested antifungal of choice, effective against all species of fungi, in vivo.

A natural fatty acid with potent fungistatic/fungicidal effect.[9]

Found in normal skin, Undecylenic acid is virtually non-toxic and irritation free.

Podiacort is the most modern formulation available for effective prophylaxis and control of . . .

Inflammation/Infection, whether bacterial or fungal, whenever inflammation and/or infection is a present or potential problem.

INDICATIONS: For topical application whenever foot or leg inflammation and infection are a present or potential complication factor, i.e., Varicose eczema, trophic ulcer, inflamed nail grooves, shoe dermatitis, callus, toe edema, varicose ulcer, stasis dermatitis, allergic eczema, corn removal and post-operative care, open wounds, contact dermatitis, fissures, infected callosity, toe bruise, Athlete's foot, infection secondary to ingrown toenail.

Not for ophthalmic use

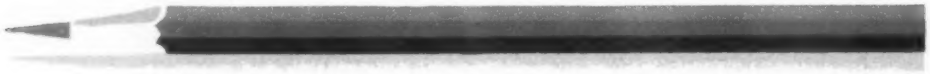
FORMULA: Each 1 gm. Podiacort Ointment contains:

Podiacort* (Podiatrex Ltd. brand of hydrocortisone diethylaminoacetate hydrochloride)	5. MG.
Neomycin sulfate (as the base)	3.5 MG.
Undecylenic acid	50 MG.

In a highly refined, cosmetically elegant petrolatum base.

Administration and Dosage: Apply to affected areas one to four times daily, or as directed

SUPPLY: Podiacort is available in 5 gm. tubes — on prescription only at prescription pharmacies across the country.



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(1) Hydrocortamate: New and Nonofficial Drugs, 1959, p. 491
(2) Samuels, Diagnosis and Treatment of Vascular Disorders, p. 515
(3) New and Nonofficial Drugs, 1959, p. 84-85
(4) Jour. of Am. Pharm. Assoc., Practical Phmcy Ed., Nov. 1959, p. 674
(5) Jour. of Am. Pharm. Assoc., Practical Phmcy Ed., Apr. 1956, p. 12
(6) Antibiotic and Clinical Therapy, Dec. 1956, 3:461
(7) Waksman, Neomycin, p. 223
(8) Lake, The Foot, 4th Ed., p. 174
(9) New and Nonofficial Drugs, 1959, p. 136
(10) Med. Clin. No. Amer., Sept. 1958
(11) Int. Rec. of Med., Dec. 1956, p. 775

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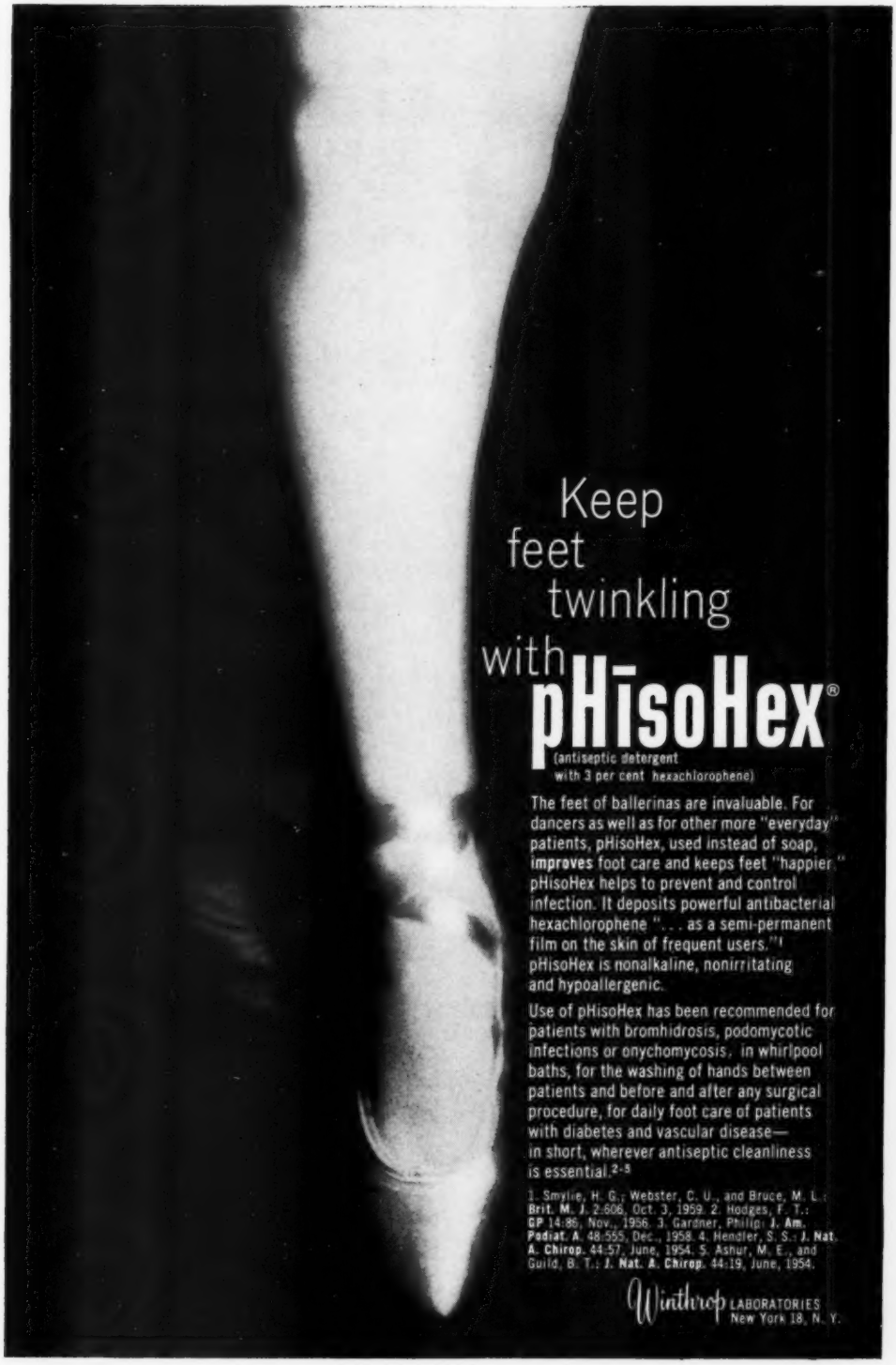
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with 3 per cent hexachlorophene)
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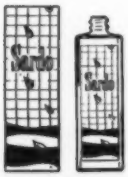

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IMMATERIAL FACTORS IN COMMON FOOT DISORDERS*

DUDLEY J. MORTON, M.D.†
New York, N. Y.

STEADILY and progressively we have observed in all biological fields, the inevitable departure from original morphological (materialistic) concepts toward expanding comprehension of the immaterial factors of physiology. Therein lie our greater successes of the future. This opening statement is the keynote of the matter I want to submit for your thoughtful reflection.

This warrants a brief initial reference to the extraordinary advances in all branches of science which we, who are living today, have had the opportunity to observe. But they have crowded in upon us so rapidly, we have not had time to appreciate and realize their basic significance. Briefly stated, *this present generation* in which you and I live, identifies the very climax, or summit, of man's intellectual powers. Slowly acquired during past generations, these modern advances have been abrupt and enormously accelerated during the adult period of our own generation.

In biology, we have been heirs to the "Morphological Period," which had reached its height at the close of the 19th Century. At that point, Gray's *Anatomy*, with over 1000 pages, was the student's "Bible" in his medical course. In the first thirty years of the 20th Century, a radical change occurred in the rapid development and expansion of *physiology*. Its original and elementary "laboratory manual" quickly grew into a volume that vied with the size of his anatomical textbooks. It was a period during which "live biology" was being instilled into the static subject of morphology (anatomy); but wherein the "materialistic" concepts of biology, originally formulated, continued to dominate our studies of all living organisms, including man. This attitude still prevails in spite of the fact that progress in the field of physiology has consistently demonstrated the reality and the essential role of immaterial factors that transcend the importance of material elements. Actually, their relationship is identical with what we commonly recognize and freely accept in all of the technological problems that lie outside the organic sphere of biology.

For example, we realize the importance of the structural (material) parts of an automobile; but it would be a useless stationary vehicle unless comparable attention was given to the gas and electricity which

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supply the invisible elements of energy whereby the purpose of the material structures is fulfilled. Materialistic biology is like the automobile without gas or batteries; physiological biology incorporates the vital *immaterial* factors.

It is in the second half of our twentieth century that we recognize the inception of a basic change in spite of the opposition of morphologists to permit official recognition of immaterial factors. The irresistible advances made in modern physiology (biochemical and biophysical) and in psychology give unmistakable evidence regarding the future direction of our progress in all biological areas of study.

In order to bring these comments to their bearing upon podiatry as the matter of our immediate concern, I would like to add the following remarks. All your older colleagues, like myself, have had the chance to observe the broad and radical transition in science generally that had its recognizable inception about thirty years ago. It is during this interval that we have seen the scattered and elementary interest in chiropody develop and expand into the highly coordinated and organized institution that is meeting here today. We, of the older generation, have witnessed the progress of the change while making personal contributions to bring it about. Your younger members were not exposed to that vivid personal experience. They have entered the field in the center of that change. As a result, they have been immediately confronted with the clash between the traditional morphological concepts and the advancing stages of our latest physiological progress. For them the conditions present two antagonistic viewpoints, structural and functional—but which should not exist as such. For only a moment of serious reflection is sufficient to establish a firm conviction that, instead of being antagonistic, their true position makes them harmoniously supplementary and complementary to each other as a *basic biological feature*. The strength of the morphological side lies in the traditional priority of its materialistic concepts. The effect has been like optical cataracts, in blinding us to the vital role of immaterial factors. On the other side, our broadening and cumulative advances in the *functional* aspects have increasingly demonstrated the reality and the essential province of immaterial factors throughout biology.

Turning to the clinical area of our professional interests, how do painful foot disorders rank as a serious problem in its relation to public welfare?

The three most prevalent sites of physical defects are the teeth, the eyes and the feet. Here we are not speaking in terms of severe and radical defects, but in reference to conditions which definitely corrupt the normal comfort and physical capabilities of the individual. *No one* escapes the experiences of dental trouble. Also, the wide prevalence of optical disorders is unmistakably demonstrated in the large percentage of people who wear glasses. Such obvious percentages may not be claimed for foot defects; nevertheless, the range of your own professional observations and the evidence of the enormous annual sales of commercial foot devices and "corrective shoes" completely justify giving to common foot ailments this third position in order of prevalence.

Next, a comment upon the nature of care we associate with these disorders. As for the teeth, highly trained professional services have been developed and established in dentistry. Such efficient care has been effectively promoted because of the associated pain combined with the inability of the individual to help himself. Similarly, the progressive course and symptoms of eye trouble have been countered by specialized professional knowledge and treatment which lie beyond the comprehension of the layman; he must receive that help from persons qualified and authorized to give it.

In regard to the prevalence of foot disorders, a fundamental difference must be recognized. In contrast to the dental caries that clearly identify the major source of dental trouble, and specific nature of refractive faults to explain the common eye defects, prevailing knowledge of foot disorders is notably vague and uncertain.

From time to time, I have asked the following question of many persons, ranging from lay patients and shoemen to members of interested professional groups, "What single factor do you think is chiefly responsible for painful foot troubles?" Almost invariably the answer has been "Fallen arches." This response definitely echoes the long-established and popular conception of foot disorders. But arch height fails to be a reliable and valid criterion when broad observations show that many feet as flat as pancakes have never experienced painful symptoms, and also that the most painful and obstinate cases involve feet with well-formed arches. The significant fact is that only during the period when the invisible functional stresses and strains of weightbearing are imposed upon the feet are clinical symptoms liable to be produced; and whenever such feet are relieved of the functional stresses, the symptoms promptly subside.

These facts transpose the problem from morphology to physiology. They identify the character of these disorders as an operative fault in the *distribution of invisible weight stresses* which are concentrated upon metatarsal bones in the front position of the foot, and which are magnified under the foot's leverage motion. Clear recognition of this essential phenomenon characterizes this feature of weight distribution in feet in its normal or abnormal manifestations, as a direct parallel to the normal or defective distribution of light rays (refraction) as the critical phase of eye function.

This comprehension of weight distribution affords a realistic criteron of analysis by which the prevalence of the foot's disorders is clearly understood and treated as effectively as our success in the similarly wide range of optical defects. Its features have been described in earlier writings. They were discussed by Philip Lewin in his book "The Foot and Ankle" (1940) and identified as the "Morton Syndrome." Although appreciating this acknowledgment of my work, I cannot help but feel that the personalized term dimmed the greater benefits of his approval. The term "metatarsalgic syndrome" would undoubtedly have invited wider clinical attention.

You may be familiar with the major features of this functional concept and its inclusion of immaterial factors. I would like to bring them more vividly to your attention with a brief comment that emphasizes the more advanced status of physiology over morphology. Their positions are comparable with the difference between a child's learning the letters of the alphabet and then learning the use of those letters to form words. The first step is elementary; the different shapes of the letters represent morphology, and primarily involve only our *sensory perceptions.* The forming of words introduces new and invisible factors —the positive but unseeable meanings; this phase is accomplished only through the development of our human *intellectual perceptions.* Morphology is restricted to materialism. In physiology, the maze of immaterial factors converts that materialism into the more profound phenomenon of realism.

Analytical study of human feet presupposes primary knowledge of their anatomical parts. Physiology imposes familiarity with the biological purpose of these parts. That purpose is twofold; vertical support of body weights in standing, and effective movement of that weight during locomotion. In both instances, the central phenomenon comprises various controlled interactions between two major sources of opposing invisible force, gravitational and

kinetic. The significance of structural features, normal and abnormal, can be understood only by knowing the varying phases of biophysical interaction between these two opposing elements of unseen force. In such analysis, the gravitational stresses, being represented in the fixed amount of body weight, supplies the basic quality of constancy; the kinetic factor is the variable one, always under the conscious or subconscious control of the individual according to the immediate functional needs and circumstances. This difference identifies the gravitational stresses as the basic criterion. This critical phase of weightbearing function is centralized in the distribution of those stresses upon the metatarsal segments of the foot; it is determined by measuring the strength of simultaneous bony contact with the ground as shared by each of these bones. In contrast, the kinetic force under changing muscular tensions and movements of the center of body weight are extremely variable. Therefore, the ratio of passive weight distribution is identified as the basic formula in studies of the foot and its disorders in the same way that refraction is the criterion of human vision and its defects.

The typically normal results in standing (A) and in locomotion (B) are diagrammed in Figure 1. Total body weight is represented in 24 equal units (black squares). For a 120 pound person, each unit would be 5 pounds.

In standing (with passive muscle tension and half of weight on each foot), the foot gravitates into mild pronation to locate the weight center midway between the medial and lateral borders, and between the heel and metatarsal heads. Metatarsal I carries two units of weight, the others a single unit each; the heel carries six units.

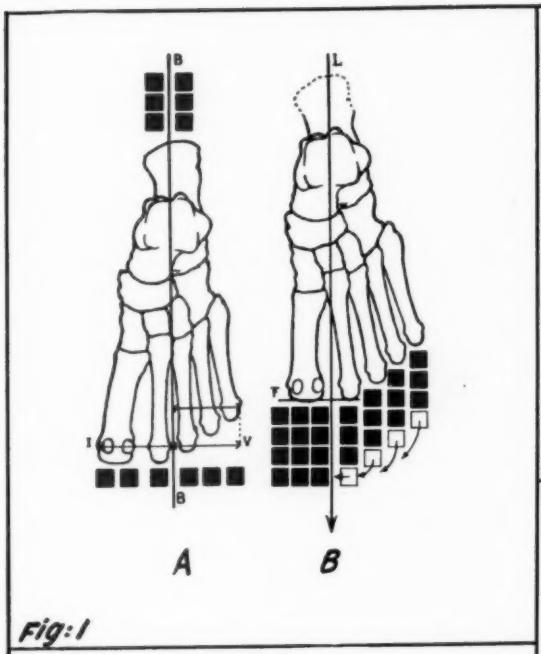
In locomotion (with increased and variable muscular activity and with *all* weight borne alternately by each foot) the pronation is overcome and the weight center is moved upon the "Leverage Axis" between metatarsals I and II. The more advanced position of their heads identifies them as the *fulcrum* of leverage action. Here, *half of body weight* becomes imposed upon the stouter Metatarsal I. Thus, the weight center is balanced on the operating leverage axis.

In the common types of foot disorder, two major causes of abnormal weight distribution are realistically and clinically identified; *laxity* and/or *shortness* of metatarsal I.

In Figure 2, normal distribution (A) is viewed from in front. (B) shows the pronated position that results from laxity or hypermobility of metatarsal I; its reduced support is indicated, also the intensified weight on metatarsals II and III. Painful callus is formed under the overloaded metatarsal heads as a characteristic feature. (C) indicates how muscular activity (supinators) overcomes the pronation; but it lifts metatarsal I out of functional contact with the ground and deflects body weight more evenly upon the four lateral metatarsals.

Figure 3 shows the normal path of weight stresses (A) in their divided relation to the heads of metatarsals I and II which serve as the fulcrum of the foot's leverage action. In (B), this action becomes concentrated upon the *more advanced* head of metatarsal II. Typically, metatarsal II becomes notably hypertrophied, and painful callus develops beneath its head as visible evidence of the constant abnormal pressure.

From these studies an effective method of treatment has been incorporated in a "compensating" insole, Figure 4, designed specifically to overcome the primary faults in weight distribution. It is not an arch support. The element A is an extension which underlies the head of metatarsal I. It is of sufficient thickness (depth) to insure a proper strength of weight bearing contact between the front end of that bone and the



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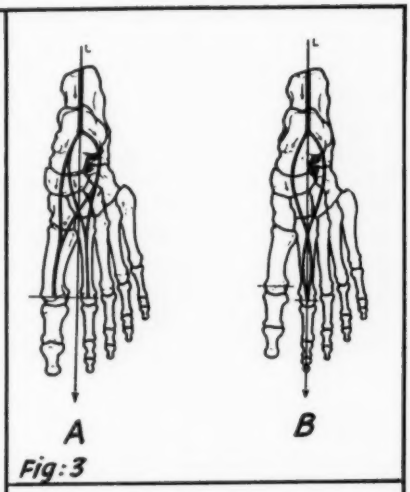

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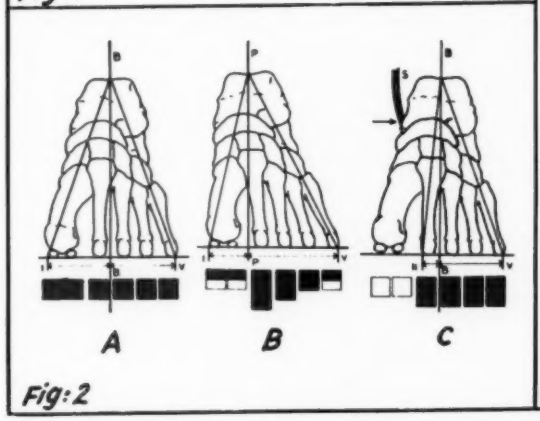

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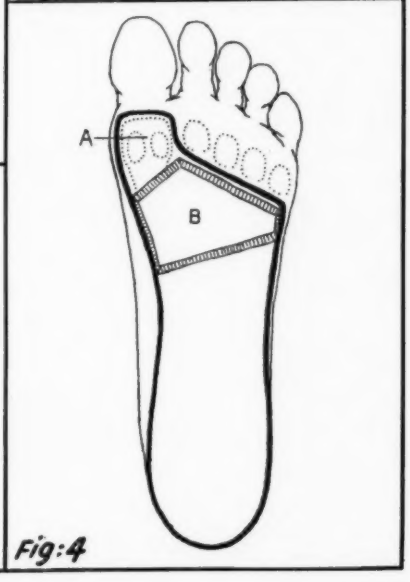


Fig:4

ground. The element B is a rubber pad extending across the insole immediately *behind* the five metatarsal heads. It is of sufficient thickness to give a level, even pressure upon the nonirritated soft tissues in back of all five metatarsal heads. Experience with this principle of treatment has indicated that with corrected weight distribution, artificial support is rarely needed except in badly deformed feet.

The insole has particular significance in its specific bearing upon the phenomena of normal and disordered weight distribution; also their effectiveness in treatment has helped in verifying the exact nature of our own common foot ailments. It corroborates the previous statement of the basic similarity between faulty "refraction" as the dominating type of eye defects and faulty "weight distribution" as the major element in clinical foot disorders.

Reverting to the broad viewpoint of the

first portion of this article, let me make the following concluding comments. The last thirty years have shown the most profound advances in all fields of science. All of us are familiar with this change and the degree to which our knowledge has ambitiously expanded into atomic power and thoughts of space travel. Both of them far transcend the materialistic range of our older ideas and concepts. In biological sciences, our advances in physiology, biophysical and biochemical, and in psychology steadily amplifying the traditional morphological concepts with new physiological vistas of scientific progress. These have been revealed by our expanding acquaintance with the coexisting and vital reality of immaterial factors that defied the materialistic perceptions of our earlier morphology. All of the clinical branches of medical science dealing with human welfare have advanced under this new impetus.

During this same period, we have seen podiatry develop under the earnest efforts of a few dedicated devotees, from a humble start, to the establishment of your highly organized colleges and institutions whose success is notably signalized in the attendance and the importance of this convention. Recognizing that the basic source of progress in all our fields of science is indisputably centered in the transition of thought from material phenomena to realization of the essential role played by the unseen immaterial factors—with this thought in mind, I have felt that the most important contribution I could make was to point out the evidence which indicates how the future progress and opportunities of podiatry are likewise related to our consciousness of the immaterial elements in studies of the human foot as the chosen center of your professional and clinical interest.

21 Claremont Ave.

RECURRING CONGENITAL TALIPES EQUINOVARUS

LOUIS BURGER, D.S.C.
Washington, D. C.

At the August 1958 Annual Meeting of the American Podiatry Association in Washington, D. C., the author had the privilege of presenting some information on the correction of congenital talipes. This consisted of a review of fifty-four cases of talipes, fifty-three of which were corrected with retention casts and the correction successfully maintained with exercise and shoe therapy. In the case of the fifty-fourth child, however, after treatment by an orthopedic surgeon, and later by the author, the foot repeatedly returned to the equinovarus position. At that time the following possible causes were suggested for the reversion of the over-corrected foot to the original deformity: (a) incomplete osseous development, (b) imperfect peripheral nerve supply to some of the muscles.

To these I now add another, (c) injury to the central nervous system at birth. To the best of my knowledge this cause is not cited in standard texts.

This paper is concerned with the last of these reasons and attempts to familiarize the readers with a method of maintaining correction in similar cases utilizing braces.

Braces

A short description of braces seems in order. Braces are orthopedic appliances used to either maintain a part of the body in a fixed position or aid and support a weakened part in carrying out its function.

Braces used in podiatry are generally short leg braces, that is, they do not extend above the knee. For descriptive purposes they can be divided into the part that is attached to the shoe and the part that is attached to the leg.

The part attached to the shoe may be either: (a) caliper, (b) stirrup.

The caliper is a metal plate attached to the rear portion of the shoe, which has receptacles to receive the bent lower ends of the uprights attached to the legs.

Calipers are inexpensive and easily removed by the patient, but have a serious disadvantage. The joint in the brace where motion takes place is not coaxial with the ankle joint, leading to difficulty in locomotion in an already unstable leg.

Calipers may be:

(a) Round calipers in which the receptable and the corresponding lower ends of the uprights are rounded, permitting motion at this point.

(b) Rectangular calipers in which the receptacles and the corresponding ends of the uprights are rectangular permitting no motion.

The stirrup type of attachment places the axis of motion in the brace at the level of the malleoli where ankle motion takes place, facilitating a more natural type of gait.

The joints of the stirrup may:

(a) have an anterior stop—a screw or spring attachment or a combination of both, is attached to the anterior portion of the joint to restrict ankle extension.

(b) have a posterior stop—a screw or spring attachment or a combination of both is attached to the posterior portion of the joint to restrict flexion at the ankle.

(c) be freely movable—no limitation is placed on either extension or flexion at the ankle.

The uprights are the parts attached to the leg. They may be single or double. A single upright makes the brace somewhat lighter, but a double upright assures more stability and support.

The uprights are attached to the leg by calf bands.

At the ankle, in order to bind the shoe more tightly to the uprights, T-straps may be used. A medial T-strap is attached to the medial aspect of the shoe, draws the ankle toward the lateral upright and is buckled around it. A lateral T-strap is attached to the lateral side of the shoe and draws the ankle toward the medial upright.

Case Report

A ten-month-old girl was brought to my office on July 23, 1957, with the following history. She was born with a deformed foot which was treated immediately after birth by an orthopedic surgeon, first with casting and later with a Denis Browne splint. The condition recurred about six months after correction was presumably achieved. At my initial examination, the patient appeared to be a normally developed child except for a severe equinovarus condition of the right foot.

Wedge casting of the foot was started on July 23, and complete correction was not achieved until November 16, 1957. This is an unusually long time for such therapy but a foot which was once corrected and returned to a position of deformity is much harder to correct than one that has never been treated before.

From that date the child wore outflare shoes and appeared to be doing well for six months, when she began to toe in again. A Denis Browne type night splint was immediately prescribed in a futile attempt to retain correction, but on June 30, 1958, the foot was found to be in equinovarus again and casting was resumed.

The child, who had began to walk, resented the casts and improvement was very

slow. After six full months of casting, both the varus and equinus were again corrected.

In one month, in spite of the use of a Denis Browne splint, the child began to toe in, and I deemed it necessary to use a short leg brace to retain correction.

The construction of the brace was as follows:

The heel was removed from a sturdy, high top, outflare shoe. A U-shaped stirrup was attached slightly anterior to the normal position of the heel so that the shoe was in a 15° abducted position and the heel was replaced.

The hinge joint of the stirrup was situated directly over the malleoli so that motions in the brace and in the ankle joint would be coaxial. A medial T-strap and double uprights were used to obtain optimum correction. An anterior stop was used at the stirrup joint to maintain the foot in a mild calcaneal position.

The child had no difficulty getting used to the brace. She wore it full time from the very first day and was able to walk, run and play with it on. The parents were instructed to replace the leather heel each time before it wore down to the metal plate. After attending to the local conditions a neurological consultation was arranged because it was noticed that the child's leg was slightly atrophied. The report of the neurologist was:

> "The examination showed an alert, cooperative child who is left-handed.
> Head: No tenderness or bruit.
> Station: No Romberg.
> Gait: She limps with slight spasticity in the right leg and inversion of the right foot. There is slight abduction of the right shoulder and slight flexion of the right elbow.
> Muscle strength and tonus: There is weakness and slight atrophy of the right leg with slight shortening. There is inversion of the right foot with weight bearing and also in repose. There are no fasciculations.
> Coordination: No cerebellar signs.
> Reflexes: The deep tendon reflexes are inincreased on the right side, especially in the leg. There is no clonus or Babinski sign.
>
> It is my impression that this represents a right hemiparesis due to birth injury and with preponderant involvement of the lower extremity.
>
> I believe that the brace which she is wearing maintains the foot in good position and I do not believe that surgery or any other radical measure is indicated at this time. There is no shortening of the tendons and no evidence of congenital dislocation of the hip. Re-examination is requested in about one year."

In reviewing this case history the following points are worth emphasis:

(1) Prognosis in most cases should be guarded. There is always the possibility of the unexpected, presenting an unforeseen problem.

(2) A condition such as talipes should not to be considered an isolated pathology. We should examine the entire child for signs of other abnormalities which can influence our treatment.

(3) Braces are at times necessary to maintain correction after casts are removed, and the parents should be advised about this possibly very early in the course of treatment, precluding unpleasant and embarrassing explanations at a later date.

2412 Minnesota Ave., S. E.

Reference

1. American Academy of Orthopedic Surgeons: Appliance Atlas, Vol. 1, Edwards Publishers, Inc., Ann Arbor, Michigan, 1952.

ERRATUM: In the article, "Griseofulvin in Podiatry" by Dr. Benjamin Feldman, page 294, right column, April issue of the Journal, the following footnote was accidentally omitted: "Griseofulvin was supplied as Fulvicin by the Schering Corporation, Bloomfield, N. J."

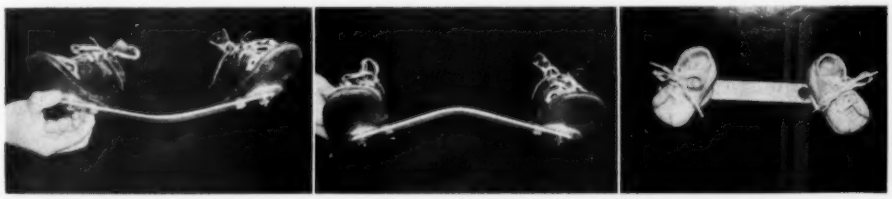
TREATING CHILDHOOD GAIT ROTATIONS WITH THE DENIS BROWNE BAR

MILTON K. KRANTZ, D.S.C.
Milford, Conn.

THE Denis Browne bar consists of a transverse bar connecting metal plates or clamps which are attached to a pair of shoes (Fig. 1). It was originally described by Denis Browne, an English orthopedic surgeon, in 1933 as a splint for the treatment of clubfoot.[1] At the present time it is most used for limb rotations such as external or internal hip rotation and tibial torsion, or as an adjunct to other therapy when limb rotation is combined with either metatarsus varus or pes valgoplanus.

The device is presented as a simple splint, not a "brace," widely used and accepted as good therapy. It is emphasized that the bar does not hurt the child and that it does the job effectively. When used as a night splint, there is no social stigma since therapy is confined to the privacy of the home.

Because they may create needless anxiety, the parents are cautioned against psychologically preparing the child for using the bar. They are advised that complete instructions for management will be prescribed at the dispensing visit.



A B C

Figure 1. The Denis Browne bar. (A) Bar bent to evert shoes for supinated gait. (B) Bar bent to invert shoes for pronated gait. (C) Straight bar with straight last surgical shoes for metatarsus varus with internal limb rotation.

In the treatment of rotational problems requiring muscle stretching, the Denis Browne bar is a very efficient device (Fig. 2 and 3). It acts upon sources of pathomechanics that may be relatively untouched by conventional shoe wedges. Although good results can be obtained up to about eight years of age, it is most desirable to apply the splint in the infant to age five group.

Other devices employing similar therapeutic principles are Yale's Clubfoot Splint[2] and Brachman's "Skate."[3]

Consultation with the Parents

After determining the need for the Denis Browne bar, a consultation is had with both parents. The mechanics of the gait problem are briefly described. Time factors for correction are approximated. If possible, visual aids are used to demonstrate the derotation process.

A B C

Figure 2. Twenty-one-month-old boy with left sided internal tibial torsion and very mild metatarsus varus of left foot. (A) Gait before correction. (B) First correction position with Denis Browne bar using two right shoes. (C) Gait after four months' treatment.

Preparation of the Denis Browne Bar

The last pair of shoes worn by the child is left in the office. If a high shoe is not available, the shoemaker is instructed to add a two-inch collar to the old oxford (Fig. 4A). This permits the addition of three or four eyelets which assure better

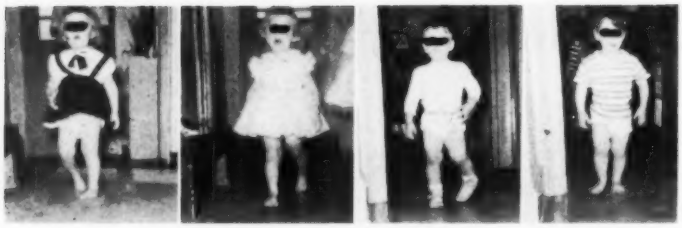


Figure 3. Illustrating the efficiency of the Denis Browne bar. (A) Internal tibial torsion in eighteen-month-old girl before treatment. (B) After four months' treatment with the Denis Browne bar. (C) Internal hip rotation and internal tibial torsion in two-year-old boy before treatment. (D) After two months on Denis Browne bar. The latter child was corrected with plaster casts in infancy for metatarsus varus but not for the accompanying limb rotation.

holding power with less irritation. Metal eyelet rings are not used.

In cases of metatarsus varus combined with internal rotation, a straight last surgical shoe or a varus corrector shoe is employed on the bar (Fig. C). If pes valgoplanus is combined with limb rotation, an inflare shoe may be helpful (Fig. 4B, C).

The toes are cut out of the shoes and, in the type bar* used by the author, discs are fastened to the shoe soles (Fig. 4D, E, F).

The cross bar is not placed until the child can be trial fitted to determine the appropriate spread for the child's size and the condition being treated. Measured from the center of one shoe to the center of the other, five and one half to eight inches are used for infants and seven and one half to twelve inches or longer for older children. Bowlegs require longer bars than do knockknees.[4]

Instructions for the Use of the Denis Browne Bar

After the proper length bar is selected, the shoes are locked into the neutral position which will be used for the first week. Instructions are now outlined for the parents, and, in some cases, the child. The procedure varies somewhat with the age of the child.

Infants. The parents are advised to apply the bar and ignore any psychological approach. Because the device does not hurt, most infants will accept it readily. Those who do not will cease resistance within a day or two. The parents must be consistent. If the bar is removed because of crying, it will be difficult to reapply.

Young Children (2-4). Most children acquire a "going-to-bed" ritual which may involve a bottle, story, brushing teeth, favorite toy or blanket. All children remove daytime clothes and don nighttime clothes. One more item is added to the agenda . . . remove daytime shoes and put on "SLEEPY SHOES." Parents and child readily accept this additional bedtime ritual.

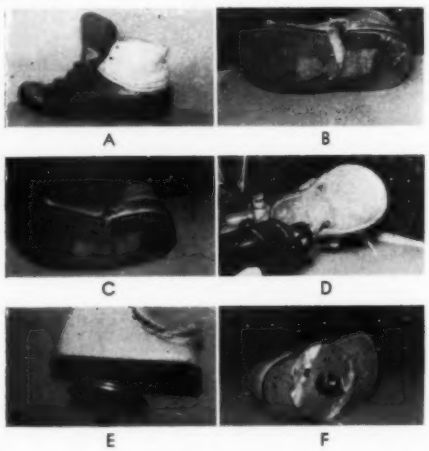


Figure 4. Preparing the shoes for the Denis Browne bar. (A) Collar added to make low shoe into high shoe. (B) Wedge section removed from sole and upper of shoe so that when laced together (C) shoe will correct for pes valgoplanus. The opposite is done for metatarsus varus. If type bar is used in which the shoes are bolted to the discs, (D) holes are drilled through the sole, (E) bolts are screwed from inside sole through disc, and (F) tightened and the excess removed with a hack saw. The central bolt which will attach to the crossbar is fitted with a lock washer to give greater security in positioning the shoes on the bar.

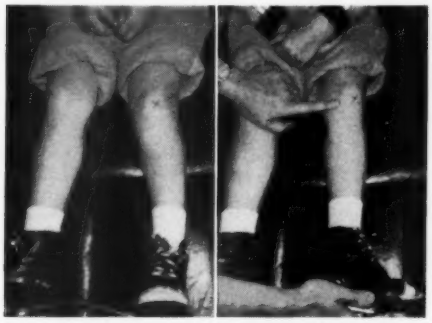
*Distributed by Foot Care Products for Children, Long Island City, New York.

Older Children (over 4). The conference must involve the child as well as the parents. The child is told in positive fashion that he is going to wear the bar each night and this will help him to "walk straight like other children do."

In all cases parents are advised to be consistent in their approach and to avoid betraying anxiety to the child. With the exception of pre-walkers, where the device is usually used for all but a couple of hours each day, the splint is to be applied each night and removed in the morning.

Treatment Management

To accomplish the muscle stretching necessary for proper derotation, definite control in treatment is imperative. In the first week the bar is maintained in neutral position simply to accustom the child to the device. A moderate correction position is then used for two weeks. Correction positions must be forcible enough to alter the attitude of the patella (Fig. 5). At monthly



A B

Figure 5. Adjusting the Denis Browne bar. Corrective positioning occurs only when the rotation of the shoe alters the attitude of the patella. (A) Left leg is in neutral posture. (B) The shoe is rotated sufficiently to carry the patella into external rotation.

visits which follow the initial three weeks, adjustments vary with gait reaction. Slow progress indicates an increase of correction angle. Although overcorrection occasionally occurs, it must be remembered that the most common cause for treatment failure is insufficient corrective force.

Simple internal rotations (internal hip rotation and internal tibial torsion) may demand treatment angles up to 180° for the desired gait effect. If it is suspected that the overcorrection will cause pes valgoplanus, the angle is reduced and greater treatment time is relied upon instead of treatment intensity. It is helpful to bend the bar upward, producing inversion of the shoes (Fig. B), and/or use a shoe on the bar which is beneficial to the valgus foot (Fig. 4B, C).

The complex of internal rotation coupled with pes valgoplanus[5] presents a therapeutic dilemma since flatfoot therapy will frequently aggravate the intoe tendency and seriously embarrass gait. It is imperative in such cases that derotation therapy using the Denis Browne bar precede shoe corrections for the flatfoot. Ordinary shoes are worn during the months in which the limb is derotated. When gait and posterior heel wear[6] return to normal, inversion therapy for flatfoot is instituted. If the inversion produces recurrence of the intoe tendency, lateral sole wedges are helpful in balancing the shoe.

When external rotation is combined with pes valgoplanus, treatment for both is administered concurrently. The night splint encourages internal rotation of the leg and shoe corrections invert the foot during the daytime. These treatments, unlike the preceding case, enhance each other.

Metatarsus varus combined with internal rotation can be treated concurrently. A varus corrector shoe (Fig. C) is used with external positioning on a Denis Browne bar. If the varus is severe, this treatment follows casting with plaster of Paris.

Results in treatment of rotations are gauged by gait response and changes in heel wear. Average treatment time using the Denis Browne bar for intoe in the two to three-year-old child is about four and one half months. Although initial results may occur sooner, extra time is allowed to avoid regressions. Occasionally intoe may recur two or three years after treatment. Sole

wedging generally suffices for mild cases but some may require a second session with the bar. As a rule of thumb it can be said that if treatment produces a mild outtoe and a change of posterior heel wear from medial to centro-lateral, there will be no significant regression.

External rotation often requires longer treatment than does internal rotation. Six months or more may be necessary, particularly in older children. Slight overcorrection in gait and change of heel wear from lateral to centro-lateral will usually insure permanent results.

Conclusions

1. The Denis Browne bar is an efficient instrument for treatment of limb rotations.
2. It is well accepted and tolerated if presented properly to the child and his parents.
3. The device should be carefully prepared and managed to fit the needs of each case in which it is used.

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THE ROLE OF THE OS TIBIALE EXTERNUM IN PATHOMECHANICAL DISORDERS OF THE FOOT*

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THE os tibiale externum is a supernumerary bone which is located near the posteromedial border of the navicular and may be fused with the navicular or attached to it. The os tibiale externum has been referred to as the tibiale externum, accessory scaphoid, accessory navicular, supernumerary tarsal scaphoid, supernumerary navicular, bifurcated navicular, navicular secondarium, and the prehallux. It is seen quite frequently.

In examination of the feet of 850 children[1], the os tibiale externum was the most common accessory bone.

There are two distinct types[2] of tibiale externum. One is a typical, usually small, accessory bone without attachments to the body of the navicular but with a well-defined round or oval outline of demarcation. The other type is a definite part of the body of the navicular but the tuberosity is separated by a fibrocartilaginous plate of irregular outline. The first type is a true os tibiale externum or navicular secondarium, which hardly ever produces symptoms. The second type often has an elongated neck articulating with the tibial side of the head of the talus and fits the description of prehallux or bifurcated navicular. It is likely to become symptomatic and may be mistaken for fracture at this "neck" of the navicular.

The os tibiale externum exists as preformed[3] cartilage at the second month of fetal life. However, it cannot be demonstrated by X-ray until the age of 9. Hiss[4] believes that the prominent tuberosity of the navicular bone may develop as a second center of ossification, and remain as a separate bone, firmly attached to the navicular.

*Presented at the Annual Meeting, American Podiatry Association, at the Waldorf-Astoria Hotel, New York, N. Y., 1959.

The most frequent age for appearance[5] of the os tibiale externum is between 9 and 11 years, but it has been seen as early as 5 years and three months.

On clinical examination there may be seen a prominence under the skin in the area of the navicular which must be differentiated in some children from a prominent talar head. In adults there is little possibility of mistaking the head of the talus for a tibiale externum, as the head of the talus is usually not excessively prominent. On weight bearing, pronation may or may not be present and the foot may be cavus or planus in type. The diagnosis is readily made upon X-ray examination.

According to some[6] of the anatomists, (Grey, Piersol) there sometimes exists a bursa between the tendon of the Tibialis posterior and the navicular or accessory navicular and it is possible that this bursa may be inflamed and irritated.

Dickson and Dively[7] have noted that the prominence of the accessory scaphoid at times impinges on the medial malleolus and leads to discomfort. To avoid this the foot is brought into a position of pronation.

Cunningham's Textbook on Anatomy says that the tendon of the Tibialis posterior spreads out and is inserted by three bands into:

1. the navicular and internal cuneiform bones,
2. the second, third, and fourth metatarsal bones, the middle and external cuneiform and the cuboid bones, and
3. by a recurrent slip into the inner border of the sustentaculum tali of the os calcis.

According to Keith[8], when an os tibiale externum is present the tendon of the Tibialis posterior, on its way to its final insertion in the first cuneiform and metatarsals, is attached to the accessory bone instead of the inferior surface of the tubercle of the navicular. With this relationship, the Tibialis posterior muscle is forced to pull backward and inward at an angle and becomes a pronator instead of a supinator of the foot. Thus its lifting effect upon the longitudinal arch is reduced.

Kidner[9] has found, in the presence of the os tibiale externum, whether as a separate bone or as a prolongation inward of the navicular, there is an abnormal insertion of the Tibialis posterior tendon. Instead of passing under the inner end of the navicular to insert in the inferior surface of the first and second cuneiforms and the bases of the second and third metatarsals, the tendon is displaced inward and upward to pass across the inner tip of the navicular, to which it is attached firmly before finally inserting into the medial surface of the first cuneiform bone. This change in course and insertion results in the loss of the tendon's normal suspensory action and transforms it into an adductor of the forefoot instead of an elevator of the tarsus and longitudinal arch.

Inward projection of the navicular, whether united or not, interferes in the full inversion of the foot, either by pinching of the deltoid ligament of the ankle or by actual impingement on the internal malleolus, which, in time, tends to increase valgus, through reflex overactivity of the abductors in their effort to prevent pain.

In the presence of the os tibiale externum, the outward excursion of the navicular on the head of the talus is increased so that the motion of the talonavicular joint is abnormally great, producing what is, in effect, an outward subluxation of the whole forefoot or an inward subluxation of the anterior end of the talus. This leads to a considerable increase of ligament strain with marked pain and foot weakness.

When the foot is completely supinated and the forefoot adducted, the tendon will seem to wrinkle or fold up longitudinally so that it is pinched between the malleolus and navicular, thus explaining the tenderness and some of the pain.

Many cases of flatfoot in which the os tibiale externum is absent show the same abnormal course of the Tibialis posterior tendon that is associated with its presence.

Harris and Beath[10] agree that the presence of an accessory tarsal scaphoid can so modify the insertion of the Tibialis posterior tendon as to materially diminish its power to lift up the inner side of the foot and so be a significant cause of diminished function (weak, painful flatfoot).

Nutt[11] states the navicular may be greatly altered in shape (Walsham, Lorenz) and its tuberosity look downward instead of inward, giving an altered direction to the Tibialis posterior muscle.

The presence of an accessory tarsal scaphoid in the tarsus, according to Harris and Beath[10], is known to be the cause of disability.

Hiss[4] states in his book "Functional Foot Disorders," aside from the callus on the skin, which is painful enough, this accessory scaphoid may become inflamed and very painful. A typical osteochondritis may be present. In most of these cases, the inflammation is from pressure, and not infection.

Harris and Beath[10] find that certain feet present an accessory tarsal scaphoid with a much enlarged tubercle on the other side as though this might represent fusion of an accessory tarsal scaphoid with the scaphoid. Also, much-enlarged scaphoid tubercles are themselves the cause of occasional disability by reason of the pressure of their prominence against the boot and apparently also by reason of their interference with the insertion and action of the Tibialis posterior tendon.

It has been emphasized by others that accessory tarsal scaphoid or prominence of the tuberosity of the scaphoid are important causes of symptoms. Our interpretation of the writers on this subject is that the symptoms are usually arch symptoms. Our observation is, however, that some symptoms are due to the pressure of the boot on the prominence of the tuberosity of the scaphoid. The impression, almost to the point of conviction, is that neither accessory tarsal scaphoid nor prominence of the tuberosity of the scaphoid has much influence in the development of symptoms, as commonly stated.

The data presented here would not support the view that operative removal of a prominent tuberosity is a valid procedure for flat foot in those cases where either of the characteristics are present. We suggest, however, when prominent tuberosity and flat foot are jointly present, that a search be made in the tarsal architecture for the cause of the complaint before undertaking the operative removal of the prominence of the tuberosity.

Hiss[4] feels that correction of pronation and restoration of foot balance will cure an associated osteochondritic condition. Occasionally removal is necessary, but it must be remembered that excision of an inflamed navicular, without correction of pronation and release from pressure, will not relieve the pain in many cases. Accessory navicular inflammation has no relation to flat foot.

Although Dickson and Dively[7] state that the accessory scaphoid or prehallux is among congenital defects causing foot imbalance in children, we find it can often be determined clinically that the same type of muscle imbalance on a congenital basis may exist without the presence of an os tibiale externum to aid in making the diagnosis. In evaluating the status of the foot we can very often see the tendon of the Tibialis posterior as it comes around the medial malleolus to its insertion in the medial aspect of the navicular, or in the inferior surface of the navicular, regardless of the presence or absence of a tibiale externum. When the entire limb is externally rotated so that the lateral border of the foot and leg rest on the table or leg rest, and the foot is strongly adducted and inverted by the patient as he actively tries to force the examiner's finger away from the

medial aspect of the first toe and metatarsal head area the Tibialis posterior tendon can usually be seen as it comes around the medial malleolus to its insertion.

If the feet do not function well and there is difficulty present, balance therapy is indicated. We can see justification for surgery only when the os tibiale externum causes difficulty that cannot be relieved by balance therapy or palliative therapy which may include injection of a local anesthetic in the area and accommodative padding, and if the insertion of the tendon of the Tibialis posterior is changed at the time of surgery to perform supination of the foot and restore the slinglike position of the tendon.

Summary

1. The particular importance[12] attaching to the presence of the os tibiale externum or accessory tarsal scaphoid lies, not in the presence of this accessory bone per se, but in the fact that it indicates an abnormal insertion of the tendon of the Tibialis posterior, which may produce a "weakfoot," the tendon being entirely or mainly inserted into the navicular.

2. It is of medico-legal importance as they have been mistaken for fractures.

3. No special sensitiveness on pressure is associated with the os tibiale externum.

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SUPPLYING THE SPARK IN THE CORRECTION OF FOOT AND POSTURAL DEFECTS

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WHETHER we be podiatrist or physical educator our specific objective has and always should be the expenditure of our efforts in seeking to better the lives of those people who come under our care—to that end our professions can profit by the interchange of ideas and methodology, and, working to gether as a team, pool our knowledge to further the growth of podiatry and corrective physical education.

The correction and improvement of body mechanics has always been a recognized part of school physical education. In this area our greatest concern is with faulty posture and foot defects. In order to achieve maximum improvement and correction of functional foot defects in his patients, the podiatrist could profit by the inclusion of body mechanics in his practice, and the utilization of mechanical devices to speed improvement and correction where exercises are indicated.

In perusing the Journal of the American Podiatry Association (August 1959 issue),

I observed under Podiatry-Chiropody Abstracts, a condensed version of an article on posture written by Myatt, in the British Chiropody Journal of January 1958:

> "POSTURE—A. Myatt, The British Chir. J., 1:7-10, January 1958. If there is inherent weakness in the feet or the shoes are inadequate for their purpose, then the structures above will be affected indirectly from this source of weakness. On the other hand if the weakness lies in the structures above the feet then the foundation will be affected."

More postural irregularities affect the feet than may be realized. Myatt draws our attention to certain postural defects, particularly those which can be corrected by simple exercise and a little effort on the part of the patient.

We all know that the foot plays an important part in the balance and movement of the entire body. Disabilities of the foot should not be considered apart from the body as a whole. A disalignment or disturbance in function in the remainder of the body is soon reflected by faults in walking and standing. Frequently, disabilities in the feet—most commonly, muscular imbalance and valgus—accompany faulty body mechanics. Disturbances in the function of the foot are reflected by change in the muscles and the joints above. With severe and prolonged disability in the foot, there may be pain in the muscles of the calf, in the thigh or even in the pelvis or the low back. Treating the foot alone when it shows disability, usually will lead to only partial correction. Good body mechanics are essential for the proper distribution and carriage of body weight in the foot, for good function of the muscles in walking and for the best circulation of the blood in the extremities. In my experience it has been found to be most practical to train the individual in good body mechanics and then to proceed to special training and exercises for the feet. For this reason disabilities of the foot should be taken up after consideration of the mechanics of the body as a whole.

Minor disabilities of the foot often improve by the correction of body mechanics. It is the more serious of foot disabilities that require local treatment in addition to general improvement of body mechanics.

Analysis of Exercises for Foot, Ankle and Knee Conditions

Any exercise designed for the development of the arches or ankles involves most of the muscles of the foot, both intrinsic and extrinsic. This is due to the complexity of the tendon structure of the foot and ankle. Moreover, practically every muscle acts upon several joints at once, as for example, the Flexor Digitorum Longus, which produces plantar flexion in the ankle as well as in most of the joints of the foot and toes. It is almost impossible to devise exercises which concentrate their action on any one muscle or, for that matter, any one group of muscles. Therefore, for corrective purposes we treat the foot more or less as a whole, using such exercises in a general program calculated to develop the strength of all of the muscles of the foot and leg. It is recommended that all foot exercises be performed at least twice daily. It is necessary to stress this point. Where correction is possible by means of exercise it is usually considered good policy to employ non-weight bearing movements in the early stages of treatment. After some progress has been made and the strength of the muscles partly restored, weight bearing exercises in the standing position as well, are ordinarily prescribed.

To reiterate, the ideal erect posture must be built from the ground up. If structural abnormalities are encountered they must be corrected or compensated for in some way before good posture can be achieved.

The feet are the foundation of good posture. Strong, muscular feet are essential to good posture whether considered from a dynamic or static aspect. It is impossible to achieve good posture, especially in the dynamic sense in a flat-footed person. If the feet are weak, developmental exercises should be instituted.

The muscles which perform the functions of the foot are, in review:

Three muscles lifting the forefoot (or extensors): Tibialis anterior, Extensor longus digitorum, Extensor hallucis.

Three muscles depress the forefoot (or flexors): Gastrocnemius, Soleus, Peroneus longus, assisted in part by the long and short flexors of the toes.

Three rotating the sole inward: Tibialis anterior, Gastrocnemius, and Soleus.

Two rotating the sole outward: Peroneus longus and Peroneus brevis.

Two bending the foot laterally: Tibialis posterior and Peroneus brevis.

For the past nine years the author has been engaged in a program of corrective physical education under the auspices of the Department of Physical and Health Education and Division of Medical Services in the City and School District of Philadelphia. During this time the opportunity has presented itself wherein studies could be made of the type and value of various exercises recommended for the correction of functional posture and foot disabilities. Experience has shown that pupils were reluctant to participate in a program where only basic free exercises were used in their corrective programs.

Through years of research the author has devised many pieces of apparatus which proved of established value in helping to supplement the normal prescribed exercises done by the children. The term—Psycho-Physiological Motivation, has been given to the method by which free corrective exercises are supplemented with apparatus especially designed to fit the need for corrective muscular movement. These devices act as stimulating motivating factors in bringing about improvement and correction of postural and pedal defects.

Apparatus, per se, is not a cure-all. It serves, however, as a contribution to the psychological aspect of motivation and becomes a tangible "something" which supplies the spark of purposeful activation to the child's mind and body. These pieces of apparatus do not serve as "gimmicks" or "come-ons" but as psychological stimuli to the participant. They encourage the youth to exercise, purposefully, to a degree that free exercise could never accomplish.

It is a known fact that adolescent children like to work with tangible and purposeful equipment and the idea of remedial apparatus goes a long way in supplying these needs. Even elementary children receive a stimulus in working when they see evidence of their body movements.

Records kept over the years showing the comparison between individuals using equipment and those engaged solely in free exercise demonstrated very clearly that children who utilized the apparatus achieved correction far greater than those who engaged only in free exercise. It also was conclusively shown that the rate of improvement was almost 60% faster in the group using the apparatus.

Educators, physicians and authorities in the field of physical rehabilitation who have observed the techniques used by the author have attested to the validity of the equipment utilized in this program. (Communications to the author from Dr. George Morris Piersol, former Dean of the Graduate School of Physical Medicine of the University of Pennsylvania, Dr. Ernst Jokl, Chief of the Department of Rehabilitation, University of Kentucky, Dr. Martucci, head of the Department of Physical Rehabilitation, University Hospital, Philadelphia.)

Demonstrations by the author at many podiatry conventions where the podiatrists themselves had the opportunity of working with the equipment met with great interest. The value of the inclusion of mechanical devices to facilitate correction and improvement of the functional orthopedic defects found in children was successfully established.

The American Podiatry Association, the

Podiatry Society of the State of New York. The Pennsylvania Chiropody Association and several other groups have recognized this contribution to the field of podiatry. Many podiatrists-chiropodists have availed themselves of similar equipment and incorporated these in their practice with great success.

The Ohio College of Podiatry at Cleveland, Ohio, has set up a clinic for remedial exercises. This clinic is equipped with devices similar to those employed by the author in his remedial exercise program in the Philadelphia School System. Students at the school will be given an opportunity to participate in the use and demonstration of this equipment, so that their training will include the methods so successfully employed by our schools in our health program.

It is also reasonable to assume that the institution of a remedial exercise clinic and instruction program at the Ohio College will help to develop a greater interest in children's postural problems. Conversely, such a program should help to develop a greater potential for a children's practice both for the clinic and the profession as a whole in this area.

The training of podiatry-chiropody students in the methods advocated and used successfully by the author will help to round out their educational program.

Those cities and areas which have utilized a remedial exercise program based on these principles have provided in varying degrees, a means by which the children in these school areas may utilize the facilities of the school in their corrective exercise programs. The author has received hundreds of inquiries from podiatrists-chiropodists as to how such a program may be carried out in their communities and private practices. In turn, on many occasions, the author has taken the time and trouble to send plans for the construction of apparatus similar to that employed in his work. From the replies received, it appears that varying degrees of success in building similar equipment were achieved.

The basic principle of the equipment is the utilization of (1) apparatus to evaluate correctly, quickly, and methodically the condition of the foot to be corrected. For example, present methods of measuring and evaluating pronation and supination are slow, often incorrect and inconsistent. (2) The device exercises must utilize the free exercise principle, reinforced and made much more effective by creating a resistance by means of springs, weights, etc. Each device must use these principles and literally mold the apparatus to fit the execution of the various phases of exaggerated muscular movement required in the correction. This must be the fundamental idea behind the planning and construction of such equipment. Results have proven that such apparatus under proper instruction fills a major gap in postural correction in the child. Further, by the addition of a resistance exercise program, the period of correction in the child is perceptibly shortened.

The author submits that in order to achieve better, quicker and more satisfactory results, podiatry should include remedial resistance exercises as part of its program in the correction of postural problems.

And as stated earlier, psychological impact of a device intended for remedial exercise is invaluable, since such apparatus is intended and set aside specifically for one purpose—to help, correct or rehabilitate a postural problem. The addition of these methods and exercise devices to the podiatric armamentarium in the management of postural foot problems in the child (and adult) will help to fill a definite gap in podiatric orthopedic care.

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AN ADDITIONAL CONCEPT IN THE CLINICAL DIAGNOSIS AND TREATMENT OF METATARSAL PROBLEMS*

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THE etiology of metatarsal problems has been ascribed by any number of doctors to such a variety of causes as ill fitting shoes, unyielding walking surfaces, variation in metatarsal length patterns, loss of the fatty cushion under the metatarsal heads, congenital causes, etc. Every advocate gives what appears to be substantial reasons to support his thesis, but to the best of my knowledge, no one has presented a comprehensive analysis of the problem, its causes and treatment.

For many years chiropodists, medical men and shoe manufacturers have used metatarsal pads, bars or buttons back of the metatarsal heads to obtain relief and often with good results. Many of us still employ this technique today empirically, but as this article develops I shall try to show why this approach has been of some help and why a variation of this pad should be used in conjunction with other modalities.

Reflexes

Robert Wartenberg, M.D., devotes twenty-five pages of his book, "The Examination of Reflexes," to the "plantar reflex," a superficial reflex, which may be elicited on many areas of the foot by tapping or stroking. The response of the patient, free from nerve pathology, will almost always be plantar flexion of the toes. Often this is associated with a plantar flexion of the foot itself and some inversion of the foot. This should not be confused with the true "Babinski sign," a deep reflex, which is elicited properly only with precise care. In most instances those of us who have been testing for the "Babinski sign" have, in fact, been obtaining the "plantar reflex" response.

From a practical point of view we should be aware that every time we bear weight on our feet and have some response to a foot irritation, such as may be caused by an irritating factor inherent in the foot or in the shoe or hosiery, the "plantar reflex" response occurs and the toes go into plantar flexion. Consider this reflex response in the patient with pain in the metatarsal area and what happens? The "plantar reflex" response soon becomes an overwhelming and constant response and the flexor action overpowers the extensors to the point where the function of the extensors as antagonists is all but lost.

Muscular Factors

There are five primary muscles attaching to the lesser toes that must be considered in the pathogenesis of problems associated with the lesser metatarsal heads. Their action is important because the development of a hammer toe or "flexion contraction" of the lesser toes, invariably brings with it associated metatarsal problems such as severe callosities or plantar keratoses.

The five muscles associated with this problem are the Extensor Digitorum Longus, which inserts into the dorsum of the distal phalanges of the lesser toes; the Extensor Digitorum Brevis, which inserts into the proximal phalanges of the lesser toes; the Flexor Digitorum Longus, which inserts into the plantar surface of the distal phalanges of the lesser toes, and the Flexor Digitorum Brevis which joins with the Lumbricales to insert into the plantar area and sides of the middle phalanges of the lesser toes.

To test the capabilities of these muscles in each individual toe proceed as follows:

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With your thumb and forefinger holding the proximal and middle phalanx, ask the patient to dorsiflex and plantarflex the distal phalanx. This will test for the strength of the long extensor and long flexor. In almost every instance you will find that the flexor has power but the extensor is unable to function or functions very weakly. Then place your thumb and forefinger on each metatarsal head and ask the patient to dorsiflex the toe, thus testing the short extensor. You will now find that this muscle is very strong. Finally, place your thumb into the "crest" area of the foot under each of the middle phalanges and you will observe the weakness of the short flexors and Lumbricales when you ask the patient to plantarflex the toes.

What is the significance of all this testing? Here we have a pattern emerging which can be very significant to us. The short extensors pull the toes back and over the metatarsal heads. The long flexors pull the toes plantarward and accentuate the action of the short extensors and the short flexors and Lumbricales are too impotent to do anything. Thus we have the perfect mechanics for a hammer toe or claw toes.

What are the primary factors that bring about this inequality between the flexors and extensors? We know that this inequality does not exist at birth and in most young children. We also know that barefoot dancers and natives that do not wear shoes have no such problems.

Local Ischaemic Contracture in the Foot

In the January 1953 issue of the Journal of Bone and Joint Surgery, Bunnell gives his findings of local ischaemic contractures in the hand in which he states that the same condition is encountered in the feet. The hand assumes the position in which it is held when entering a coat sleeve with the thumb drawn into the palm of the hand and pointing toward the third metacarpal. He states that the condition is caused from a decreased blood supply which is in the nature of a local congestion or lessening of the circulation. The most common cause is a swelling of the hand in a plaster of paris encasement or even in too tight an elastic bandage. The tightness may be over the whole limb, or it may be in the hand or only in part of it. The contracture may also follow gross damage to the great vessels and nerves well up in the arm. In most cases both the fingers and the thumb are involved, but in some the involvement in one or the other may be paramount. These findings may be elicited by the following test: in contracture of the interossei or lumbrical muscles, they are first made taut by passively forcing the metacarpophalangeal joints into extension. Tapping on the fingernail will then meet with such resistance that the distal two finger joints cannot be flexed, while they flex readily if the metacarpophalangeal joints are held in flexion. Ischaemic contracture in the foot is evidenced by a similar test. If there is contracture of the thenar muscles, the thenar eminence feels indurated, and an attempt to widen the angle between the first and third metacarpals meets with rigid resistance as the short adductors of the thumb and secondarily all other tissues have contracted.

The main complaints are that the hand cannot be opened for grasping, the thumb cannot be extended from its position in the hand, and the metacarpophalangeal joints cannot open from their flexed position. There may also be complaints of weakness, numbness, anesthesia, induration and signs of poor nutrition of tissues.

I am certain that all of you recognize this condition that Bunnell describes so well in the hands, as we see them in the feet every single day. Because of weight bearing, the apparance of the forefoot and toes differs considerably from that of the hand. We find the toes hammered with the great toe in the valgus position. Also because of weight bearing we find that the bony structures and joint structures show some signs

of deformity similar to those of early deformative arthritis, but there are no arthritic signs elsewhere in the body.

In the feet we must ascribe the causative factor to shoes that reduce the normal circulatory flow. This is aggravated by the increase in the volume of tissue fluids from early morning to late evening in the average patient. While there are the other causative factors described above for the hand which could also apply to the foot, we can be certain of the shoe factor causing circulatory constriction.

Awareness of these factors increases our responsibilities to our patients. Orthopedic surgeons treat hand problems surgically in almost every instance. We must develop palliative and mechanical techniques and use surgery only when other efforts are inadequate.

Treatment

I have approached this finding in my own office for more than two years with good results in instances where the patient has been cooperative, because the treatment does require such cooperation.

Since our basic problem is to reverse the mechanics that have brought about this condition, we must combine mechanical methods with exercises to strengthen the weakened muscles. The primary muscle involved is the Extensor Digitorum Longus, which, in many instances, has developed contractures, part of the muscle has become "pathologized" with scar tissue and fat replacing the muscle cells. In most instances some of the muscle can still be regenerated sufficiently to return the foot to a state approaching normal function.

The most important exercise is extending and stretching all of the toes in both feet whenever the patient thinks about it—preferably hundreds of times a day. Flexion exercises are avoided entirely because they create antagonistic power which the patient already has in superabundance. Three months of this exercise will often produce favorable changes.

With this exercise we fit the patient with a pair of balance inlays which reach to the distal end of the shoes. This inlay always contains a metatarsal pad of the "mayo" design, there being no attempt to "push-up" into the hollow posterior to the metatarsal heads. The prime purpose of this pad is to reduce the "plantar reflex" spasm that occurs when pain is present. When this spasm is absent the foot has a great opportunity to lengthen and become rehabilitated. In addition to this we place an 1/8" pad at the distal end of the appliance so as to elevate all of the distal phalanges of the lesser toes and thus effect a lengthening of the digits. The elevation in this area also assists the Extensor Digitorum which is being strengthened by the exercises.

Finally, we see the patient once every week at the beginning for routine massage, manipulation and physical therapy. The shoe problem is routine and only a shoe that is roomy enough to carry out our work is required. However, we do insist on the shoe having a sturdy rear part and sufficient flexibility in the fore part to allow for good muscle action without cutting off circulation.

The appliances are made to a slipper cast model of the foot taken with the feet at rest and in extension. It is my opinion that the balance inlay is a most essential part of the treatment.

Summary

Contracted toes and their relationship to metatarsal problems have been discussed. Special reference has been made to digital musculature, plantar reflex spasms, and ischemic contractures. Some suggestions for treatment were described.

This paper is not presented as a panacea for all metatarsal and digital problems. It is but another step in the direction of a solution to one of our prime foot problems, suggesting a clinically feasible approach on a physio-pathologic basis.

25 E. Washington St.

SUGGESTED ETIOLOGY OF THE ABDUCTED GAIT OF PRONATION

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We recognize that the direction in which the foot points in gait is generally determined not by the foot, but by the muscles of the hip acting on a neutral femero-acetabular joint. When these muscles act synergistically and in balance, they maintain this neutral position and the toes point straight ahead. When, however, the muscles whose normal action is to externally rotate the extremity actually exert a greater pull, a different position of the foot is achieved, that of external rotation or abduction of stance and gait. When the internal rotators exert the greater pull then obviously the reverse, or adducted gait results. Though at first glance it would appear that a perfectly neutral or straightforward position of the toes would be the ideal, the stance of the great majority of individuals is that of moderate external rotation. It has been stated[1] that an angle of out-toeing of about 30 to 40 degrees gives greater lateral balance to the body. However, in- or out-toeing does not contribute much to lateral balance as this is accomplished adequately by the separation of the legs. Toddlers do not usually fall sideward, but forward or backward.

There are other entities affecting the hip, such as coxa valga or varum, or congenital dislocation of the hip, which may alter the normal straight-toe gait, but these are not considerations in the subject of this paper.

These are the major factors in abduction and adduction of stance and gait as controlled by the hip. Obviously, there are other factors influencing the position of the foot. For example, a foot with flaccid pronation everts and the forefoot abducts. In spite of the fact that such a patient may stand with the legs perfectly straight and the knees facing directly forward, the feet will still adopt a position of out-toeing. This is an abducted stance-gait that is independent of hip factors.

Usually, in these cases, as well as forefoot abduction, there is external rotation of the entire limb. It is speculative whether an external rotation may initiate pronation since it places the foot at a mechanical disadvantage, or whether pronation, because of forefoot abduction, or other factors, initiates abduction gait (distinguished from abduction of the forefoot alone). Many individuals exhibit forefoot abduction or external rotation singly, but they do seem to occur together in the greater number of patients.

Perhaps the dominant patho-mechanical change which takes place in the pronatory deformity of the foot is the forward, downward and inward displacement of the talus. The following attempts to show that this action plays an important role in producing external rotation at the hip.

The talo-crura articulation permits motion in but one plane, forward and backward, or extension and flexion of the foot at the ankle. No other motion is normally permitted because of the strong mortising effect of the malleoli. When the talus deviates in pronation the tibia and fibula are twisted internally (tibial torsion), following the deviation of the talus. This twisting effect causes the medial malleolus, which normally is above and anterior to the lateral malleolus to move downward and backward, while the lateral malleolus, which normally is below and posterior to the medial malleolus, moves upward and forward so that they assume, with relation to the ankle, "relative malleolar parallelism[2]." Motion at the ankle joint is in a forward-inward, backward-outward plane. If we wish to move straight ahead, the ankle

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is not in a position to flex and extend directly forward and backward. Also, the entire knee joint will rotate inwardly and move forward medially, in the same plane of motion as the ankle, because of the tibial torsion. An extremely clumsy scissors gait would be the result if accommodation did not occur.

If the entire extremity is externally rotated slightly, the forward-inward, backward outward motion of the ankle, although remaining the same with relation to the foot, becomes a straight forward and backward motion with relation to the line of progression and now the knee may flex and move forward in this straight line. This external rotation, or abducted gait, is maintained so that at the ankle, motion will be in the line of progression. The greater the amount of talo-calcaneal pathology (or inward rotation of the talus) the greater must be the external rotation of the limb to compensate for and overcome the change in plane of motion at the ankle joint.

One other point can be made. The superior surface of the talus is wider anteriorly than posteriorly and the difference is greater in some individuals than others. This may account for those cases where external rotation does not accompany pronation. In these cases the narrower portion of the talus is in the ankle mortise and there may be sufficient "play" so that tibial torsion is not produced.

Summary

A hypothesis is presented which may explain the very frequent concurrence of pronated foot and externally rotated, or abducted, gait. The rotation is an accommodation of the extremity to mechanical pathology presented by a downward, inward and forward displacement of the talus associated with a primary eversion of the calcaneus. Without the accommodation an awkward scissors gait would be present. With the external rotation, movement at the ankle and knee can occur in the plane of direction of movement.

This hypothesis has been derived from a mechanical and anatomical analysis and radiologic findings. It is believed that experimental or other evidence will substantiate the hypothesis, although none has been here presented.

No inference should be made from this discussion that a similar argument could be made for internal rotation or adducted gait.

1422 West Monroe Street

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"One cannot divide the body into parts for repair as he can an automobile but must treat it as a human being and the treatment given must be the best that the combined knowledge of science can afford."

W. J. Mayo.

MANAGEMENT OF LIMITED SUBTALAR MOTION*

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LIMITED sub-talar motion and its associated problems is a commonly seen but usually unrecognized or misdiagnosed syndrome. In its severest stages, when there is gross deformity, it is more easily recognized and is known as peroneal spastic flatfoot.

The classical peroneal spastic flatfoot is a relatively rare condition which is characterized by a rigidly abducted forefoot, a rigidly pronated rearfoot, and severe contraction of the digital extensors. These positions are maintained in such extremes that the deviation from the normal is easily recognized by simple inspection of the foot and observation of the characteristic limping gait.

The literature is replete with papers on this subject advancing such etiologies as hairline fractures of the tibia, stress on an already present weakfoot syndrome, or congenital bony anomalies and acute inflammatory processes in the talocalcaneal ligaments.

It is this last etiology as was projected by Lapidus that has led us to a method of therapy which we believe to be the most rational and effective that we can offer our patients today.

Our experiences have convinced us that an inflammatory process in the sub-talar joint, whatever its cause, is productive of peroneal spasm and limited sub-talar motion.

The tarsal anomalies that have been described in the orthopedic literature as being the cause of peroneal spasm, are present in only a small percentage of these cases. These structures are productive of spasm in that, by mechanical irritation, they produce an inflammatory process.

In our series of 28 cases, 3 were produced by septic arthritis of the joint after penetrating wounds. Six were produced by sprains and fractures. In only three cases were we able to demonstrate unilateral calcaneonavicular bars. Fifteen patients in this series were being treated for rheumatoid arthritis and subsequently developed peroneal spastic flatfoot. In many instances this was bilateral. One of our cases was an adult female under care for pulmonary tuberculosis. There had been a sudden bilateral onset of peroneal spasm without history of injury. X-rays were negative for tarsal anomalies.

The high correlation between rheumatoid arthritis and peroneal spasm was striking and would seem to substantiate the Lapidus theory.

On the assumption that peroneal spastic flatfoot is produced by subtalar arthritis, be it septic, traumatic or what-have-you, we introduced 25 milligrams of hydrocortisone acetate into the sub-talar joint of a young adult female who gave a history of 20 years' duration dating from a penetrating wound.

Relief from pain occurred in approximately 48 hours. A definite decrease in the characteristic rigidity was noted. This procedure was carried out in 1953. A check two years later revealed no regression to the previous state.

In general, our results with this type of therapy have been extremely gratifying. Relief from pain usually is achieved within 48 hours with some increase in motion. We have recently modified our injectable by using equal parts of the tertiary butyl acetate of prednisolone and the more soluble prednisolone 21 phosphate. This has eliminated most of our post injection pain.

Experience has further taught us that

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additional therapy usually is required to break the reflex spasm and adhesions which have formed in these joints rigidly held in abnormal positions for long periods.

Adjuvant therapy is as follows: The peroneal nerve is injected at the level of the head of the fibula. This produces relaxation and complete motor paralysis of all the muscles involved in the syndrome, namely, the short and long peronei and the long tibial extensors. The foot is then mobilized by (1) inverting the heel, (2) adducting and abducting the forefoot, (3) inverting the forefoot.

This therapy is repeated at intervals until the patient is symptom free both objectively and subjectively, or we feel we have reached the maximum of improvement possible. It is interesting to note that all our cases except one (a boy in early adolescence) have exhibited continued hypertonicity of the involved muscles, but this must be differentiated from the rigid spasm which was originally present. These individuals are able to invert the heel and to walk comfortably over uneven terrain. 90% of normal motion and function is usually obtained.

The only additional therapy we have been using in these patients is a mechanical support and we suspect this may be due to the ingrained habits of our schooling.

The commonly seen cases which are frequently missed by the practitioner may show some of the following characteristics. The peroneal spasm is such that it produces no gross visible deformity. However, the patient is unable to invert or evert the heel, or can only do so with difficulty. The patient often localizes the complaint to the ankle joint or his "arches" and is so treated by many practitioners.

Patients with rheumatoid arthritis commonly develop full-blown peroneal spastic flatfoot when there is extension of the arthritic process to the sub-talar joint. On x-ray examination, in most of our cases of peroneal spastic foot, we have been able to visualize a definite area of rarefaction at the anterosuperior spine of the os-calcis.

Many patients who are suffering with this condition develop a voluntarily controlled spasm which overlays the involuntary spasm. This results apparently from apprehension and fear of the pain induced by accidental movement of the joint, and can be overcome with voluntary muscle relaxants. We have had our best results with meprobamate which has both tranquilizing and muscle relaxing properties.

By far the greatest number of our cases have been patients who have suffered a trauma or a penetrating wound with resultant infection, exclusive of the rheumatoid group. It is our opinion that local inflammation on an infectious or traumatic basis is the basic underlying cause of this sub-talar syndrome. We have found no evidence of hairline fractures of the tibia in our cases. We have seen three demonstrable congenital anomalies all of which responded well to the above therapy indicating to us that, while the congenital anomaly may predispose to local trauma and inflammation, it is the inflammation and not the anomaly which produces the problem.

606 Hollywood Avenue

"Money should never be the incentive for doing a job."

Sal Lazzaretti
in Guideposts

RELATIONSHIP OF ATAVISMS TO OTHER ETIOLOGIC FACTORS IN PATHOMECHANICS OF THE FOOT*

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A RECENT paper[1] in Military Medicine by Wikler and Hale posed the very interesting question, "Is the Cause of Pes Valgoplanus (Flatfeet) Unknown?" A fairly extensive review of the literature by them indicates to them at least, that (1) there is little agreement about the cause of fallen arches, (2) none of the current theories are widely accepted, (3) comprehensive exploration of the cause of this condition has never been attempted in the United States. They also point out that theories advanced today are in conflict "with the often-noted phenomenon that habitually barefooted people have no arch complaints at all."

I would contend that they have overlooked two important points: "Habitually barefooted people" live in a culture where there are little or no flat widewalks or paved streets, and even the dwellings have uneven rough earthen floors. I think all of us would agree that if the peoples of advanced cultures, living in urban centers, did not wear shoes, there would be a much greater incidence of "flatfeet" and other pathomechanical disturbances of the foot.

Almost all of us walk with a characteristic stride and have a characteristic stance. The individuality of the stride is so marked that an experienced ear recognizes an individual by his footfall before that individual comes into view. In a primitive society, the uneven underfooting would distribute stresses of gait and stance over a variety of pathways in the foot. The unevenness of the ground surface will result in a foot one time being slightly inverted, and the other time slightly everted, or dorsiflexed or plantarflexed or combinations of these, depending on the exact contour of the terrain. In modern communities the flat underfooting does not allow for this variety of positions. Stress is generated in the foot during function and the one adopted attitude tends to result in the stresses being concentrated in a single pathway. Therefore, it is not barefootedness that is responsible for better feet in unshod peoples, but the repetition of myriads of minimal stresses impinging in the same area of the foot in people's environment whose terrain is almost exclusively flat surfaces, that accounts for the large number of pathomechanical difficulties today. It is interesting to note that pathomechanical problems are fairly recent in medical literature and can be correlated with urbanization.

The other point is that too frequently, the treatment of pathomechanical problems is related to the position of one anatomical part to another. We are forgetting that the problem is one of tissue trauma. This trauma results in various pathologies which can be osteitis, periostitis, synovitis, capsulitis, fasciitis, myositis, arthritis of various forms, fibrositis and, of course, many others. The tendency in treatment is to attempt to correct the attitude, believing that this will restore function. Treatment should be directed to alleviation or eradication of the pathology and measures taken to reduce the stresses impinging on the foot.

The various atavisms in the foot that have been recognized provide for varying degrees of individual resistance to the stresses impinged upon the foot. Also there is a great deal of variation between individuals, and from time to time within individuals, in the capacity to adjust to the

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† Secretary and Editor, American Podiatry Association, and former Director of Clinics, Professor and Head of Department of Orthopedics, Illinois College of Chiropody.

stresses to which the foot is subjected. We can therefore postulate that pathomechanical problems arise from the interaction of the following factors:

(1) Morphological variations of which atavisms account for the greatest number.

(2) Capacity for adaptation to stress.

(3) Stressors acting on the foot.

Morphologic variations which have an effect on pathomechanical states of the foot will be either intrinsic to the foot or extrinsic to the foot, occurring in the legs, knees, thighs, hips and back. Morphologic variations can be in the soft tissues or in the bony architecture. The atavisms in the foot, which is our direct subject here today, are morphologic variations of the bony architecture intrinsic to the foot. These can be grouped into those which occur in the metatarsal area of the foot, those which occur in the midtarsal area and those which occur in the rearfoot. By far the best known of these, of course, is the short or hypomobile first metatarsal segment. The foot with this atavism, if subjected to amounts of stress to which the individual is unable to adjust, may develop the well-known syndrome associated with the name of one of the other speakers on this platform, Dr. Morton. Other commonly recognized atavisms relate to the sustentaculum tali, the shape of the navicular and the various tarsal coalitions.

Adaptation to stress occurs in two ways: mechanically, through the neuromuscular apparatus and its various reflexes, including conditioned reflexes, and biochemically, through the vascular system and its contents and especially the products of the pituitary-adrenal axis. There is also evidence to indicate that some very local vasomotor reflexes will contribute to adaptation. We should be aware that a careful balance of the adaptive mechanisms results in normalcy (homeostasis), but that this delicately balanced mechanism can be tipped in one direction or another so that pathology results when there is either hypo or hyper adaptation.

In our neuromuscular apparatus, we should consider nociceptive extensor thrust, myotatic reflexes. The conditioned reflexes responsible for walking and standing, may also become involved. Here we may be concerned with antero-posterior stability and lateral stability.

The pituitary adrenal axis elaborates a series of biochemical substances which modify and regulate inflammatory response in tissues. These obviously have an important effect on adaptation, especially at the site where the stress may produce trauma. It is the action of these biochemical substances that makes hydrocortisone and its derivatives such a valuable adjunct to the local treatment of pathomechanical states.

The stressors that impinge on the foot can be classified as follows:

(1) Society and the foot
  (a) The surfaces we walk and stand upon.
  (b) The wearing of footgear.
  (c) Socio-psychological pressures.

(2) Mechanical stressors
  (a) Macrotrauma; sudden massive injuries may not permit the individual an opportunity to adjust.
  (b) Myriad microtraumata; these hundreds of thousands of tiny injuries can result from footgear failure, occupational activities, overweight and poor stance and gait.

(3) Systemic disorders, of course, influence a great deal the tissues of the foot as will local pathologies.

In a previous paper[2], I pointed out the possibilities that could occur to a second metatarsophalangeal articulation in the presence of a short or hypermobile first

metatarsal. I should like to recapitulate them here for you.

"In a hypothetical metatarsophalangeal articulation, the following are some of the possible reactions to the microtraumatically induced stresses: (1) Redistribution of weight stresses by a myotatic response through the neuromuscular apparatus. This could result in effective adjustment without other changes and perhaps no symptomatology. (2) Local and superstructural postural adaptations through nociceptive and supplemental reflexes. This could result in static disturbances such as strained foot or weak foot. (4) Cortical and midbrain evoked muscular adjustments which might parallel any of the previous three. This of course would eventually produce a conditioned reflex state no longer under immediate volitional control. In another situation in the foot, this might be a peroneal spastic case. (5) Psychic maladjustments operating through volitional control or one of the mid-brain or spinal centers, paralleling eventually the type of affair in (4). We might also have some autonomic adjustment here, which might include hyperemia with consequent edema. It is also possible that in this stressed state sudoriferous glandular activity might be increased. (6) A combination of prophlogistic and antiphlogistic response through the humoral mechanism for stress adaptation would provide for a balance between a catabolic and an anabolic state. The ideal balance would leave a state of health. (7) It is possible that dysfunction, or what could be called dysadaptation, might result in an excessive antiphlogistic response. This conceivably could terminate in a local necrosis that one might see in a perforating ulcer. (8) Stress might induce a hyperprophlogistic response. The same response could be elicited by dysfunction or imbalance between the prophlogistic and antiphlogistic (dysadaptation) so that excessive quantities of PC are present and a hyperprophlogistic state would occur. One of these conditions, which we have come to find in ever increasing proportions, is a periarthritis of the 2nd metatarsophalangeal articulation. This is a hyperprophlogistic dysadaptation response to stress and warrants further discussion as a prime example of what occurs typically in a type of dysadaptation in the foot."

Similar possibilities can occur with respect to any morphologic variation.

What I have been trying to say is that feet with atavisms and other morphologic variations have a structure which does not resist stress too well. If this foot does not adapt successfully to the stressors acting on the foot, pathomechanical problems arise.

The foot was evolved in a primitive environment. Today's flat surfaces concentrate stress pathways and good modern footgear can help to disperse the stress.

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"The noblest question in the world is, What may I do in it?"

in Poor Richard's Almanac

ATHLETIC STRAPPINGS REDUCE THE INCIDENCE AND RECUPERATIVE TIME OF BASKETBALL INJURIES

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ATHLETIC strapping is quite common in organized football, yet it has been greatly neglected in another major participant sport, basketball. Many coaches, athletic directors, and other responsible personnel do not stress the importance of athletic strappings in basketball. Many are of the opinion that basketball has a much smaller injury potential than football, primarily a contact sport.

Although this study is limited, we feel that some conclusions can be drawn. The injuries, findings and results are of significance, and should be carefully considered by the podiatrist as all injuries that occurred in this study are within the scope of podiatry-chiropody.

Method

This study deals with one high school having an enrollment of 270 students, 130 male. Twenty-eight boys participated in basketball in reserve and varsity capacities.

At the beginning of the season, the value of wearing adhesive strappings during the game was not readily accepted by some of the team members, but as the season progressed, injuries occurred during the practice sessions and game time among players who were not strapped. This made all of the team members far more conscientious and cooperative in reporting for strappings.

Survey

The following injuries occurred during the nineteen game season. In every case the injury was to a player who had not been strapped.

a) one fracture of 1st cuneiform and base of 2nd metatarsal

b) one anterior dislocation of foot at angle joint

c) one mid-tarsal sprain

d) one tarsometatarsal sprain

e) one severe contusion of lateral maleolus

f) one severe contusion of 5th metatarsal head

g) one severe contusion to the talus and the os trigonum

h) five inversion ankle sprains

Twelve disabling injuries occurred to the team which totaled 28 players. Forty-three percent of the team was injured sometime during the course of the season.

Treatment

All of the injuries were brought to our immediate attention. Because of early treatment, all of the injured players with the exception of the fracture and ankle dislocation cases (which were immobilized in plaster casts) were able to resume active participation within one week post injury.

In addition to the strappings used in treatment of specific injuries, 110 strappings were applied for preventive care, primarily to those players who spent the greatest amount of time in active participation.

Summary

a) The injury potential of basketball seems to be underrated by podiatrists.

b) Athletic strappings markedly reduce incidence and severity of injury. In this particular study, every injury occurred to a player who was not strapped. There was not one recurrence of injury to a post injury case while the player was strapped.

c) Immediate diagnosis and care is essential for early rehabilitation.

d) The podiatrist plays a vital role in the care and treatment of basketball injuries as a large majority are in the field of podiatry.

e) Working with young athletes and athletic personnel helps to increase the public's awareness of the profession.

Comment

Although the percentage of injury was high, the team was able to be rehabilitated to a point of winning the County championship. We feel that the care rendered the team helped, not only physically, but also the mental attitude of all concerned. The value of proper podiatric care was highly appreciated by the players, staff, and families involved.

It is the authors' belief that greater attention should be directed towards the athletic injury. It can be a vital part of practice with a minimum of time devoted to it.

The authors appreciate very much the cooperation of Mr. Forrest K. Sharrock, Head Coach and Reverend Thomas McLaughlin, Athletic Director of Rosary High School, Columbus, Ohio.

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IMMOBILIZATION CASTING

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A FEW general statements will be appropriate before describing any immobilization casting techniques. All statements refer to the foot and leg.

Contrary to general belief, no cast, regardless of thickness or rigidity, will immobilize completely any body part. The soft tissues interposed between the cast and bone will yield to some extent. Therefore, "immobilization" is a relative and somewhat arbitrary term.

Immobilization is used for more purposes than "fixing" fractures. Among the numerous conditions where this type of cast might be indicated are: correction of deformities, sprains with suspected fractures, severe sprains and strains, postoperative conditions of various kinds, and some arthritic cases.

The following comments are made without regard to diagnosis.

Skin Preparation

A detergent of choice should be used to cleanse the skin thoroughly. Follow with acetone, alcohol or carbon tetrachloride. The latter is preferred. Skin must be perfectly dry before proceeding further.

Do not shave the foot or leg. Not only will shaving lead to considerable discomfort to the patient but is an invitation to a folliculitis or other dermatoses.

If desired, Tincture of Benzoin Compound may be applied. Rubber cement thinned with equal parts of acetone may be used. Apply either with brush.

Many operators simply cleanse the skin and proceed to the base wrap. Others will apply the plaster directly to the skin without a base wrap. We prefer to cleanse the skin and apply base wrap next.

Base Wrap

The oldest material used and still used is cotton wadding. However, wadding is being replaced by other materials. Stockinette is used widely but it, too, is being replaced because of its thickness.

Tubular gauze is excellent but both stockinette and tubular gauze have a distinct disadvantage in that they do not fit snugly over prominences such as the mal-

leoli. Additionally, plaster must be applied with considerable tension.

We have found Webril to be excellent and to have many advantages. Two important advantages are: 1) Webril will fit snugly over prominences and 2) plaster need not be applied with tension.

Cuffs may be made by running the material superiorly and inferiorly in sufficient length that it may be turned back over itself. Over the "turn-backs" plaster strips may be applied to anchor the cuffs. This procedure will result in neat, thin cuffs which are not only firm but smooth.

Adjuncts

Padding to prevent discomfort and decubitus ulcers is a matter of choice. When padding, use as little as possible to accomplish the purpose. If other material than Webril is used as base wrap, padding may be made of adhesive felt, moleskin, foam rubber, or some similar substances. Do not use solid or semi-solid material such as rubber, cork or combinations of same. When Webril is used, appropriate folds, torn strips or extra turns will suffice.

Some ingenuity is required to finish off the toe end of the cast neatly. If it is desired to extend the cast a bit beyond the toes, here is a "gadget" which may be used successfully. Cut a three-inch piece of oiled paper or heavy cardboard about a foot long. Encircle the toes. Extend the cut piece a little beyond the toes and secure with a short length of adhesive tape. Plastic tape is better for this purpose. When the cast has begun to set, the piece may be removed easily and without distorting the cast.

Cuffs may be made of stockinette or tubular gauze if cut into short lengths and drawn over the foot and leg. Fold back after the cast body is applied. Attach the cuffs with narrow strips of surgeon splints or split sections of roll castings.

There are numerous types of walking pegs but we prefer the Stryker because of its convenient shape and ease of application. The characteristic under-cut is a distinct advantage for security purposes.

The attaching of a walking caliper requires some experience and is not recommended for the first few casts, if ever.

Casting Materials

Plaster splints, 3 or 5 inch widths, are used most frequently.

Roll plaster is best and most practical for our use.

Bulk plaster is used sometimes when "evenness" is required. Dental plaster is best for this purpose.

Catalysts may be used only when small casts are applied. Catalysts shorten the setting time and increase the rigidity of the plaster in which it has been mixed. We do not need the rigidity but we do need the time. There are several fine catalysts on the market. Most of them are either resinates or acrylates.

Colored plaster rolls are available in several colors such as: red, green, blue, yellow. Colored plaster is used sometimes in children's hospitals as a novelty. There is no difference in the chemical composition between colored plaster and the regular white type.

Compression dressings are used after removal of the cast to help control edema and give some support to the parts involved. It is usually advisable to apply a compression bandage as a matter of precaution. Gauze bandage is not good for this procedure. Ace bandage or similar type is best. Elastoplast is excellent if one is certain that there will be no skin irritation from the adhesive. There are many makes of casting materials used for compression bandaging but they will be omitted for the sake of simplicity. Most of these, in general, resemble unna paste boots.

Many types and kinds of plaster have been used by us and our preference is Gypsona. This is not meant to infer that others are not as good. It means simply that we have become accustomed to Gypsona.

Cast Removal

Removal of a cast requires much patience and care. Too frequently, trauma occurs at the time the cast is removed. Great care must be exercised at this stage. To facilitate cast removal, many implements have been devised. Most of these are not inexpensive. Unless many casts are going to be involved, it is not necessary to purchase an electric cast cutter.

These are some of the simpler tools which may be used. Cast cutting scissors are almost indispensable. They will work well if the cast is not thick. A cast cutting knife requires much time. Obtain a good pair of tin-snips—no less than 14 inches long, with quarter-turned and pointed tips. These will cut almost anything. Large bandage scissors are handy for cutting the base wrap.

One of the constant dangers present while removing a cast is abrasion of the skin. Here is another "gadget" we have devised to prevent such abrasions. From heavy aluminum, cut a 2 by 5 inch piece. Round the corners and smooth well with abrasive paper. Cut a slit transversely halfway through the piece and bend up to a right angle one quarter of the piece on an axis parallel with the length of the piece. This will form a broad spatula-like implement which may be slipped under the cast. The cast may now be cut over the inserted section without traumatizing the patient.

The electric cast cutter is the best of all the instruments but it will be the most expensive piece of equipment used for casting purposes. Our preference is the Stryker.

Types of Casts

A short leg cast extends from the head of fibula downward to, or beyond, the toes,

A sural cast extends from a line level with the Triceps sural and downward as far as desired. (We have designated this a sural cast to distinguish it from others.)

Infrequently a shorter case is used such as in case of a bunionectomy when orthopedic correction or stability is needed.

Unless there is good reason, use either a short leg cast or a sural cast. You will find that for most cases a sural cast will serve as well or better than a short leg cast.

Position

There are several positions in which the leg and patient may be placed while applying the cast but the following two are much preferred.

1) The leg is placed in a dependent position while the patient sits on a high seat. The foot will extend and invert. Therefore, it will be necessary to hold the foot in the proper position until a sufficient wrapping support is given. It may be necessary to use this position due to infirmity, peculiar injury or for other reasons.

2) For our convenience, the better position is with the patient prone and the leg flexed vertically. This will cause the foot to fall into almost perfect alignment. Be certain to cover the thigh and area under the thigh for protection against excess plaster.

Make quite sure that the trousers worn by the patient will slip off over the cast. Especially must care be taken when applying a cast to a female leg encased in slacks.

Procedure

1. Cleanse the skin.
2. If desired, apply Tincture of Benzoin Compound or rubber cement.
3. Apply base wrap. Begin application exactly as though putting on a figure-8 gauze bandage. Leave enough at either end for cuffs.
4. Pad prominences.
5. Apply roll plaster but without tension. Dip each roll in water and after bubbling has stopped, give a firm but gentle torsion twist to remove excess water. Hold roll at each end so that plaster will not squeeze out.
6. Do not twist roll while applying same. When change of direction is indicated, make a tuck before or after the change

of direction. Smooth the tuck immediately. After each roll is applied, smooth out by stroking with palms of the hands. Keep hands quite wet while smoothing.

7. Heel may be covered or open—depending on type of cast desired. If heel is to be covered, cut several plaster strips and apply first. Do not be afraid to use plenty of strips for this covering. Many times we apply three or more 3 to 5 inch surgeon splints over the calf, heel and foot before starting the roll plaster. This will provide good rigidity and a lighter cast.
8. Fashion the cuffs.
9. Allow one hour for the cast to set and begin dehydration.
10. No weight should be carried on the cast for one full day. We do not apply the walking peg at this time.
11. Crutches should be given the patient. He should be instructed thoroughly in the use of the crutches—otherwise, further trauma may occur. Always give a pair of crutches, never a single one. Place crutch tips six inches in front of and six inches lateral to forefoot. Allow width of hand between top of crutch and axilla. Adjust grips so that elbows will be bent at about 15°. The object is to bear weight on the grips and not on the tops of the crutches. Too many times nerve lesions are induced by bearing weight at the axilla. Even paralyses have developed. Teach your patient to walk, turn, ascend, descend and otherwise handle himself. This is best done by standing in front of the patient and holding onto his belt. If a woman is being taught, devise a belt. Patient must not "swing through" but use the respective crutches as legs. The crutch is swung with the leg on that side—not alternating with it. Crutch tips should be of the wide variety.
12. On the second day apply the walking peg. Place it in such position that a transverse plane through the talonavicular joint will bisect the treading surface of the peg. Keep peg at right angles to the foot and vertical to the leg thrust. Observe that there is no pronounced genu valgum or varus if the leg is being used as a gauge for alignment.
13. No specific time is here suggested for maintaining the cast on the part. This will depend upon many factors such as: extent of damage, type of damage, age of patient, location of trauma, weight of patient and many others.
14. Recall and check cast at intervals not to exceed one week.

Summary

One of the simpler methods of applying immobilization casts has been presented with some precautions given. Some innovations have been suggested. Some hints concerning removal of casts have been outlined.

401 Florida National Bank Bldg.

"Human responsibility is fearful and glorious. Whether we possess one talent or ten God Almighty wants our joyful cooperation."

Anon.

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

A PRACTICAL, INEXPENSIVE HAND-PIECE SUCTION APPARATUS

RICHARD A. HAGLUND, D.S.C.
Davenport, Iowa

In 1958, Rosenthal[1] presented a fine article on the dangers of lung infection from dust produced in various podiatry procedures. In particular he cites the reducing of hypertrophied nails with or without obvious mycotic involvement as being dangerous to the health of the operator. In the same issue Sherman[2] wrote on a suction device he uses in his office. In his

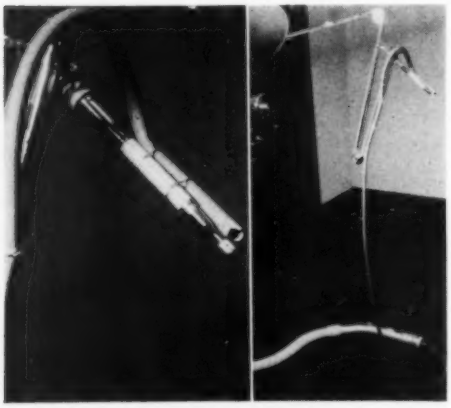

Fig. 1. The completed suction apparatus. Left, note banding of hose to drill. Right, note manner in which hose connects with vacuum source.

article, Sherman states, "Many types of hand-piece suction attachments have been designed but have proven impractical." I am not familiar with other hand-piece designs but would like to present my own hand-piece suction attachment which I have had in use for almost two years. It has a large enough lumen to provide for adequate suction and is small enough in outside diameter so as not to interfere with grinding technique.

Fig. 2. Suction apparatus in use.

Any vacuum cleaner may be used. Aside from the vacuum cleaner, total costs of materials is nominal and they may be obtained from a hardware and "dime" store.

They are:

1. Five feet of rubber tubing. 3/8" lumen, 7/16" outside diameter.
2. Tapered cap from a plastic squeeze bottle mustard jar with 1½" inside diameter. (This is a standard "dime-store" item and conveniently fits most vacuum hoses.)
3. A small amount of aluminum wire, or better, aluminum bands to secure hose to arm and hand-piece of drill.

Construction

1. Cut off the tip of the tapered end of the cap far enough back to allow maximum lumen. Insert end of cap into tubing after applying rubber cement to both surfaces. For extra strength, wrap wire around union and twist tight.

2. Cut forty-five degree angle in opposite end of hose so that it will angle toward the burr. Then attach with wire or bands as visible in Figure 1.

After very little practice you will become accustomed to the "new feel" of your hand-piece.

The greatest single advantage to this device is the elimination of the time consuming bother of attaching and removing a cumbersome and unsanitary piece of tubing and elastic from the patient's foot or the foot rest. Also, it is a much more professional-looking piece of equipment since the vacuum and vacuum hose need not be in sight.

709 Union Arcade Bldg.

References

1. Rosenthal, Roland M., D.S.C.: *Use of Suction in Preventing Lung Irritation and Infection in Chiropody*, J.A.P.A., Vol. 48; No. 7; pp. 287-289; July 1958.
2. Sherman, Bernard D., D.S.C.: *A Suction Apparatus for the Removal of Ungual Dust*, J.A.P.A., Vol. 48; No. 7; pp. 289-291; July 1958.

A SIMPLE METHOD FOR CURING DYNAMIC LATEX DEVICES

ARTHUR E. HELFAND, D.S.C., F.A.C.F.O.*

Philadelphia, Pa.

WITH much emphasis being placed upon the rehabilitation of the foot with the use of dynamic plantar shells and dynamic orthodigital devices, liquid latex procedures have become commonplace in the podiatry office.

One of the major objections of the busy practitioner to the liquid latex procedures has been the time needed to cure the device. The longer time that the patient must remain in the treatment room has necessitated the use of a small hot and cold air dryer, many of which do not have a professional appearance and seem to have no place in the doctor's office.

In an attempt to find an inexpensive curing agent which could be used to speed up the coagulation of liquid latex and not change the properties of the device, the following preparation was found to fulfill our needs and be safe for the patient.

A mixture of equal parts of plain household white distilled vinegar and inexpensive isopropyl alcohol placed in an atomizer and sprayed on the final latex coat, will coagulate the liquid latex within seconds and give enough of a set to permit the patient to leave the office.

A stock solution of a quart of the coagulant can be prepared for less than one dollar by using a pint of the white distilled vinegar and a pint of denatured isopropyl alcohol. The inexpensive denatured isopropyl alcohol will mask the odor of the vinegar. A small amount can then be placed in an atomizer for use by the doctor.

The orthodigital appliance is made on the patient in the usual manner; i.e., rubber cement, felt, rubber cement and latex. The coagulant is then sprayed on the final latex coat, blotted with a paper towel, and the product powdered. The patient is now ready to leave the office. If at future visits, additions are needed, they are applied in the same manner with the coagulant sprayed on after the final latex coat. No separation has been noted after the use of the coagulant.

When making the dynamic rubber butter type of plantar insole, the rubber butter is applied to the plantar surface of the shell and the coagulant sprayed on. The area is blotted with a paper towel and sprayed with powder. The shell is placed in the shoe. The moulding properties of the rubber butter are retained and no separation of the material from the shell or sticking to the shoe has been noted. The molded insole can be finished in the usual manner.

With this vinegar-alcohol coagulant, we have a stable, safe, quick, and inexpensive method for liquid latex coagulation procedures.

St. Luke's and Children's Medical Center

*Active Staff, Secretary, Department of Podiatry, St. Luke's and Children's Medical Center, Philadelphia, Pennsylvania.

JOURNAL

OF THE

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A. RUBIN, D.S.C., Editor

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PRESIDENT'S PAGE

OUR STATUS IN THE ARMED FORCES AND VETERANS ADMINISTRATION. Let us briefly review our position in these areas. How can any of us forget the heart-breaking efforts of many individuals and officers of this association that laid the groundwork for our participation in these vital areas. The discouragements that each of us felt when the need for our services, which was so obvious, was denied the men under arms, with the exception of the Navy. How proud and thrilled we were when it was announced, just a few years ago, that the Profession now held commissioned status in the Army and the Air Corps. And now the Veterans Administration is calling on us to fill a need that is so important in the rehabilitation of the veteran.

A clear indication as to the value of our services has been visually demonstrated. The Army proudly presents its exhibit, "The Podiatry Service in the Army Medical Corps," at many scientific assemblies. This exhibit has been shown at a number of important meetings in this country. For the second time within one year, closed circuit color television, on the Podiatry Service at Walter Reed Army Medical Center, has been produced, from which a kinescope film was made. Young graduates in podiatry-chiropody can today find new careers in federal service that were unheard of a short time back. It is quite possible that within a few years we will be unable to fill the demand of public and private agencies for full-time podiatric care.

MARVIN W. SHAPIRO, D.S.C.

IS THE INCREASE IN DUES NECESSARY?

SECRETARY and EDITOR'S NOTE: Our 1959 House of Delegates approved an increase in the National annual dues assessment from $30.00 to $40.00. The Board of Trustees (then known as the Executive Council) through President Shapiro, presented this memorandum to the House of Delegates explaining why the increase was necessary and how the additional funds would be used. The increase comes into effect this June 1, 1960, and we believe all members will have much interest in this special report.

Do you believe that our major immediate concern is our educational system, its needs and products? Do you believe that large sums of money must be raised for education through the Fund for the Advancement of Podiatry-Chiropody Education? Do you believe that our schools cannot function solely with the funds provided by tuition and clinical fees? Do you believe in the development of specific types of public relations programs? If you believe our profession needs these things, and you should, and if you desire to see them brought about, you can do nothing else but provide the necessary support and funds!

In the past several years, many resolutions have been referred to the Executive Council suggesting certain programs and facilities. The Budget Committee has had resolutions referred to it from the House of Delegates requesting funds totaling as much as $50,000.00 in one year. As you know, funds were not available for the purposes stated in said resolutions. Accepting the obligations implied in our Constitution and receiving direction from the House of Delegates through the resolutions mentioned, it is proposed to increase our dues by $10.00 per annum.

To implement your desires and wishes, the proposed increase in dues will provide from $40,000.00 to $50,000.00 annually. The Executive Council suggests, for your deliberation and approval, that these sums be apportioned as follows:

1. **Council on Education**—The Council on Education has advised us that there are certain areas of activities which they are desirous of expanding, which would increase total responsibility of the Council. It is estimated that the needs are:

a. Professional administrator and/or consultants in education, student recruitment, etc.	$12,000.00
b. Secretarial service for the professional administrator or consultants and for the activities of the Council on Education	5,000.00
c. Expenses for setting up, in our Washington headquarters, for special equipment, supplies, etc., and for travel expenses of the staff and members of the Council on Education	5,000.00
Total estimated budget	$22,000.00

It is intended that these monies will provide counseling service to the Council on Education and our schools, to enable them through self-evaluation, to improve the curricular, personnel and physical facilities. This will also provide for professional recruitment personnel to visit throughout the country those individuals and agencies that are concerned with recruitment in the health fields. In this it would improve and expand our present career guidance and student recruitment programs which the Council believes are of paramount importance.

It will also be possible for the Council on Education to improve and maintain liaison with national bodies of interest to

the Council on Education's and the profession's needs.

2. **Fund for the Advancement of Podiatry-Chiropody Education** — To reach the primary objectives of this Fund, it is necessary to place its activities in an administrative staff which will contain, or be part of, a public relations fund raising organization. The estimated budget for this area of contemplated activities is as follows:

a. The obtaining of a public relations fund raising firm $10,000.00
b. Stationery, postage, mailings, personal contacts, etc. 5,000.00

We have been advised that fund raising is essentially a public relations project. Public relations is, indeed, a very vast field. We are concerned with those areas which present the most pressing problems. To this end, it is our considered opinion that the fields of labor health and health insurance relations need immediate consideration.

3. We are estimating that a **Labor Health Relations Program** would require about $5,000.00.

Labor health relations, like community relations, in essence, is "dealing with people." The goal of labor health relations is an understanding cooperation and good will of the union membership and leadership. In its simplest application, labor health relations consists of making friends, talking to them about our work, listening to them talk about their work and helping them, or accepting their help when appropriate.

The contemplated program of a labor health relations effort would:

a. Concern itself with the organized labor movement in the U.S.A.
b. Require preparation of a brief and other pertinent releases and materials, to the national AFL, CIO and its divisions.
c. Require meetings with responsible leadership of the AFL, CIO and its affiliates, especially in New York and Washington and other cities if necessary.
d. Require conferences between the American Podiatry Association and technical representatives of the AFL, CIO departments such as Health and Welfare and Community Services.
e. Require labor press relationships, to be established on a regular basis.

In order to accomplish this task, the complete understanding of the A.P.A. membership and its affiliated groups will be necessary. This project must be considered as a continuous one and unless this is done, the A.P.A. and its affiliated state societies will miss the opportunity to be included, or to strengthen their position in the community medical care picture.

4. It is estimated that a **Health Insurance Relations Program** would need about $1,000.00.

Many of our members have been faced with the problem of securing payment for services rendered to patients who are covered by private insurance company health and welfare contracts as well as individual contracts that pay benefits for such treatment. The issue generally arises out of the language contained in the policy which requires the patient to be under the care and treatment of a "legally qualified physician and surgeon." The attitude and present policy adopted by some insurance carriers excludes the Podiatry-Chiropody practitioner from the definition of "physician" with consequent denial of payment for services rendered. We have an analogous situation with some Blue Shield and corporate medical indemnity plans.

The importance of this issue makes it imperative that all of our state societies begin to organize to meet this problem without delay. To this end the appropriation of $1,000.00 is being suggested to consult with our insurance consultant and then

prepare the necessary data for our state organizations and permit a coordinated attack on this problem.

The above programs will require an estimated budget of $43,000.00. We bring to your attention that these are contemplated expenditures and if, at the end of our fiscal year, there remain unexpended funds in any or all of these categories, these unexpended funds would remain in escrow for the respective projects and would be disbursed and spent only with the approval of the next or succeeding House of Delegates.

We should understand, and not adopt the common concept that public relations is simply newspaper notices and an occasional write-up in magazines or periodicals, or even an occasional TV or radio appearance or mention. Our present programs in the fields of Federal Relations, Career Guidance and Intra-Professional Relations are ideal forms of good public relations. Presently the materials for these programs are provided through our Audio-Visual Council and our present extremely limited pamphlet and leaflet information materials. Believing that you wish more of these materials to expand one facet of our public relations program, the Executive Council is suggesting that you authorize the establishment of a $10,000.00 refund capital account for the production and distribution of necessary public education and information materials, for continuation and expansion of this service. In the event that this House of Delegates approves our aforementioned increase in dues, as specified in the projected areas, it may be entirely possible for the Budget Committee to find this suggested $10,000.00 from our present income.

Now, looking to the future, we cannot be a static organization and adopt programs when we are forced, by necessity, to do so. We should attempt to have a certain amount of vision and foresight. To this end we present the following:

1. As some of these programs develop and as some of these needs are met and as we acquire further income, you may wish to establish a public relations staff to prepare and disseminate information regarding our activities. News is usually not manufactured but reported. At present we do not have sufficient news to warrant maintaining a full-time staff, but as we continue to expand, as we continue to undertake newer activities and programs, we will shortly be reaching a point where such a staff will be necessary.

2. Any national organization worth its salt must have a central library of professional, educational and statistical information. As we are being accepted more and more as the authority on foot health in this country, more and more peoples and agencies call on us as the authoritative source for information on foot health. We must be prepared to have this information. We have a beginning in the William J. Stickel Memorial Library. It is basic and necessary that all available information on any and all aspects of foot health and feet be correlated, compiled and established in a central location.

Our Association's growth, our professional advancement, and the future of those who succeed us depend on our willingness to face up to our responsibilities as we recognize them. We are confident that the House of Delegates, for the membership, will accept this responsibility by the enactment of the proposed amendment to increase the dues.

For the Executive Council
Marvin W. Shapiro, President

God first, others second, yourself third.
Unknown

OFFICIAL NOTICE
ANNUAL MEETING — HOUSE OF DELEGATES
AMERICAN PODIATRY ASSOCIATION
AND
ANNUAL SCIENTIFIC SESSIONS
AMERICAN PODIATRY ASSOCIATION
NATIONAL ASSOCIATION OF CHIROPODISTS
TO COMPONENT STATE SOCIETIES AND AFFILIATE ORGANIZATIONS

Announcement

In compliance with Article VI of the Constitution and Chapter IV, Section 5 of the Bylaws, you are hereby notified that the Annual Meeting of the House of Delegates of the American Podiatry Association will be held at the time and place indicated on this announcement for the purpose of receiving reports of officers and committees, for the annual election of officers, for action upon regularly offered amendments to the Constitution and Bylaws and for such other business which may be presented.

Time and Place

Forty-first Annual Session of the House of Delegates, Drake Hotel, Chicago, Illinois, August 25, 26 and 29. The first session will begin 9:00 a.m. on Thursday, August 25th.

Representation

Chapter II, Section 5 of the Constitution provides that component state societies be represented in the House of Delegates in the ratio of one delegate for each one hundred members or fraction thereof as of the close of the fiscal year ending May 31, 1960.

Credentials

The authority of each delegate or alternate shall be evidenced by a Credential Certificate signed by the president and secretary of the component state society. The Secretary of the Association will forward these certificates to state society secretaries upon receipt of an executed Designation Form, supplied by the Secretary of the Association, for each duly chosen delegate and alternate. State secretaries shall then send Credential Certificates to the designated representatives. Credential Certificates must be presented in person to the Credentials Committee at the time and place of the meeting set forth in this announcement. No delegate or alternate will be seated until his credentials have been approved by the Committee. Each delegate or alternate must present evidence of registration for this annual meeting and of being in good standing.

Resolutions

Proposed resolutions intended for submission to the House of Delegates should be in the hands of the Secretary on or before July 15th.

Annual Scientific Sessions

As provided in Chapter XI, the Forty-eighth Annual Scientific Sessions of the American Podiatry Association, National Association of Chiropodists will be held at the Drake Hotel, Chicago, Illinois, August 27th through 30th, for the presentation and discussion of subjects pertaining to the science and art of Podiatry-Chiropody.

Authorization

In accordance with the above article, chapters and sections, the Board of Trustees has authorized that the scheduled meetings be convened at the time and place indicated above.

Registration

Each person, whether or not a member, sixteen years of age or over, attending the convention, shall be registered and admission to meetings, clinics, lectures and all other convention activities will be refused to those not so registered. All members shall pay the registration fee set by the Board of Trustees. Non-member podiatrists-chiropodists will not be permitted to register.

Invitation to Members

A cordial invitation is extended to all members. Each component state society and affiliate organization is urged to send as large a delegation as possible in addition to the accredited representatives of the House of Delegates.

MARVIN W. SHAPIRO, D.S.C., *President*

Dated: May 1, 1960
Attest:
A. Rubin, D.S.C., *Secretary*

PROPOSED AMENDMENTS
to the
CONSTITUTION AND BYLAWS
of the
AMERICAN PODIATRY ASSOCIATION

Propositions A Through L

At the organization meeting of the Board of Trustees following the 1959 House of Delegates, the Board directed the Association's counsel and secretary to review the Constitution and Bylaws as adopted by the House and to make suggestions and recommendations for possible revisions in view of the fact that numbers of changes were made from the floor of the House and there might be some need for correction and clarification. Their suggestions were considered, reviewed and revised at the January 1960 meeting of the Board of Trustees and were adopted by the Board for submission to the 1960 House of Delegates as Propositions A through L, inclusive, here published.

CONSTITUTION

Proposition A
Article IX (Page 2, Lines 28-34)

The new section dealing with referendums, while being an improvement over the corresponding section in the old Constitution, in our opinion, requires some further revision. At present, five component state societies comprising not less than 300 members can call for a referendum. There is no provision specifying the majority required for a state society to take such action. Without such a provision, the entire section may be ineffective. Further, there should be some procedure enabling individual members to petition for a referendum, irrespective of whether the requisite number of state societies concur. We would suggest the deletion of the first sentence and substitution therefor of the following:

"Individual members may petition for a referendum on any question not in conflict with the Constitution and Bylaws upon blanks to be furnished by the Secretary of this Association. The receipt by the Secretary of at least 500 individual petitions shall be sufficient to authorize a referendum. Component societies may petition for a referendum on any question not in conflict with the Constitution and Bylaws upon blanks to be furnished by the Secretary of this Association to the Secretary of the component society. Upon the filing of a certificate by the Secretary of at least five component societies comprising not less than 300 members stating that the referendum petition has been adopted by a majority of the governing body of the component society or by a majority of its members (whichever may be applicable), a referendum shall be held in the manner herein provided.

Submitted by the Board of Trustees.

BYLAWS

Proposition B

Chapter I, Section 2A (Page 3, Line 24)
and Section 2B (Page 3, Line 45)

The privilege of petitioning the Board after denial of membership should be limited to the particular kind of membership involved. It would appear that for reasons of clarity, these lines should read:

"who has been denied *active* membership in a component society."

"who has been denied *associate* membership in a component society."

Submitted by the Board of Trustees.

Proposition C

Chapter II, Section 3 (Page 4, Line 81)

In order to assure that the national organization be informed within a reasonable time of any changes in a component society's Constitution and Bylaws, we would suggest the addition of the following sentence to this section:

"All changes in the Constitution or Bylaws of a component society shall be reported to the Secretary of this Association within ninety (90) days of adoption."

Submitted by the Board of Trustees.

Proposition D

Chapter II, Section 7 (Page 5)

There is at present no reference to the possibility of suspension or revocation of charters. We suggest the following additional section be added to this Chapter: Section 7—Suspension or Revocation Charters:

"Charters of component societies may be suspended or revoked for cause after reference to a Board of Inquiry and action by the House of Delegates in accordance with Chapter IX of these Bylaws."

Submitted by the Board of Trustees.

Proposition E

Chapter IV, Section 12B (Page 8, Line 41)

We suggest deletion of the clause "except the annual budget." Since the Budget Committee is given express authority over the annual budget, this exception appears unnecessary and confusing.

Submitted by the Board of Trustees.

Proposition F

Chapter IV, Section 13B (Page 8, Line 63)

It seems that the language of this Section is not as clear as it should be. The intent appears to be that the Budget Committee of the House and Budget or Finance Committee of the Board act jointly and in effect become the Budget Committee of the House. Subsection (a) should be revised as follows:

"a. Personnel: The Budget Committee shall consist of six members, three (3) members to be appointed by the President from the members of the House at least twenty (20) days in advance of each session and the remaining three

(3) members shall consist of members of the Budget or Finance Committee of the Board of Trustees. The chairman of this Committee shall be appointed by the President."

Submitted by the Board of Trustees.

Proposition G
Chapter IV, Section 13C,
Subsection (c) (Page 9, Line 9)

In order to be consistent with other provisions regarding duties of the Speaker, the word "President" should be substituted for "Chairman." The privilege of appointing committees is inherently one of the President; the Speaker's functions are essentially parliamentary in nature.

Submitted by the Board of Trustees.

Proposition H
Chapter VIII, Section 1,
Paragraph (e)—Council on Education (Page 13, Lines 32-33)

Delete the words "for action"—last word in line 32 and first word in line 33.

Submitted by the Board of Trustees.

Proposition I
Chapter VIII, Section 1,
Paragraph (f) (Page 13, Lines 41-47)

We recommend revision of the language of this paragraph as follows:

"The Council on Education shall adopt rules and regulations for its own government and respecting the matters within its jurisdiction, all such rules shall be subject to the approval of the House and shall not be inconsistent with the Constitution and Bylaws of this Association."

Submitted by the Board of Trustees.

Proposition J
Chapter VIII, Section 1,
Paragraph (g) (Page 13, Lines 48 and 52)

We recommend the following revisions for this paragraph:

"Add, in line 48, following 'formulate' the word 'administer' and add, in line 52, following 'subject' the words 'to the approval of.'"

Submitted by the Board of Trustees.

Proposition K
Chapter IX, Section 3,
Paragraph F (Page 15, Line 49)

In order to have language consistent with the recommended addition of Section 7, in Chapter II, this paragraph should be revised as follows:

"The House of Delegates may accept, reject or modify the findings of a Board of Inquiry provided, however, that when the findings of a Board of Inquiry include a sentence of expulsion or suspension for more than one (1) year or the suspension or revocation of the charter of a component or affiliated organization, such findings shall not be upheld nor shall it be imposed by the House unless approved by a two-thirds majority of the Delegates present and voting. Any action by the House shall be final and conclusive."

Submitted by the Board of Trustees.

Proposition L

Chapter XIII, Section 2 (Page 17, Line 7)

It is assumed that the intention was to provide for approval of special assessments and increase in dues by a two-thirds (2/3) vote of the members of the House *present* and *voting*. The words "present and voting" should be inserted on line 9 before the words "for approval."

Submitted by the Board of Trustees.

Proposition M

Add to Chapter X, Elections, Line 3, Page 16:

"All ballots must contain the same number of candidates as there are positions to be filled."

Submitted by the New Mexico Podiatry Society.

Proposition N

Add another paragraph to Chapter VIII, Finances, Page 17:

"Upon notice from a component society, that one of its members has forfeited his membership or has been suspended, the Secretary shall immediately remove said name from the membership roster and rescind all the privileges pertaining hereto."

Submitted by the New Mexico Podiatry Society.

FORTY-EIGHTH ANNUAL MEETING
DRAKE HOTEL, CHICAGO, ILLINOIS
AUGUST 25-30, 1960

The theme of this important Convention in Chicago will be "Health Care of the Aging." This vital subject will be discussed in a Symposium Session on Geriatrics and is being held as a contribution to the 1961 White House Conference on Aging.

All podiatrists-chiropodists realize how important foot care is for their aging patients and should try to equip themselves with all the knowledge possible to do the best job in this field. At the scientific sessions, geriatrics will be covered in areas such as: diagnosis, peripheral neurological manifestations, peripheral vascular diseases and dermatological lesions of the feet. You may learn also how we can best fit into foot care for the aged in hospitals and nursing homes.

Your scientific committee also is arranging other fine lectures and demonstrations in the fields of surgery, orthopedics, radiology and podopediatrics.

All in all, along with the many social events being planned, this should be a worthwhile convention and we hope to see you in Chicago in August. Oh yes, bring your golf clubs; a golf tournament is also being planned.

NEWS OF THE PROFESSION IN GREAT BRITAIN

FRANKLIN CHARLESWORTH, F.Ch.S.
Manchester, England

A regular series of "letters" about the profession in Great Britain, by Mr. Charlesworth, Editor of the British Chiropody Journal, or arranged for by him, will appear in this column.

Our American friends will be following with interest the recent developments in British Chiropody. The State Register will soon be an accomplished fact, the end result of thirty years of constant endeavour. It is not the Register the profession would have liked. Firstly, to be lumped together with a group of other technical and professional bodies whose scope and conditions of practice are so different from our own is not what we originally envisaged. Secondly, whilst only those on the Register will be allowed to take appointments under the National Health Service and in municipal clinics, others can practice without let or hindrance, irrespective of training or qualification.

General or even restricted implementation of a Chiropody Service under the National Health Service has not been realised. The Minister has farmed off a restricted chiropody service for the aged and physically-handicapped to the local county or municipal authorities to be operated by medical officers of health. The service is to be financed from the Government block grant made to local authorities to meet certain special expenditure.

This scheme was launched without prior consultation with the profession, a most unstatesmanlike procedure, very unwise as it has antagonised a large proportion of the chiropody profession.

This service is already running into trouble, in fact there has been nothing but trouble since its inception.

On the intervention of the chiropody organizations, the Minister agreed to chiropodists treating the patients in their own surgeries as an alternative to clinics but as he left the decision with the medical officers in question, with very rare exception, these gentlemen have gone all-out for municipal clinics under their own control.

This, of course, cuts across established private practices which may well be adversely affected. Local chiropodists who agree to work in such a service may virtually be helping to injure their own practices; time alone will tell how this will work out in practice.

Whilst sessional service is a very useful method of implementing one's income, it serves no useful purpose if it is at the same time damaging one's private practice.

There is also the possibility that as soon as the service has been sufficiently expanded and chiropodists are more readily available the sessions would be discontinued and full-time chiropodists engaged* as a matter of economy so that not only could local practitioners have helped to damage their own practices, but the compensative income from sessional employment would cease.

It would be interesting to contemplate the engagement of the full-time staff. Would experienced practitioners with years of experience and, of course, on the higher grading for salaries be engaged, or young, new-qualified practitioners because their salary grading would be considerably less?

Those of my colleagues whose practices are situated in what may be termed "high-class" districts or whose patients are drawn from the high salaried section of the community may well think the possibilities outlined somewhat pessimistic. What we must do, however, when planning or legislating

*Since first writing this letter, this has occurred in at least one instance.

for our profession is to take a very long view and also to think not only of how it will affect a fortunate section of the profession but how to safeguard all sections of it. The practitioners in the working class districts could be affected seriously by free treatment offered in their districts other than through them, with compensatory payment on the lines first recommended by the Society of Chiropodists to the Minister of Health.

I feel you will be interested in these problems that are besetting British chiropody at the present time, because you may one day be faced with similar problems and it is possible you may profit by our mistakes or, better still, note how we eventually overcome the host of teething troubles that beset major stages in our professional advancement.

I do feel that the present Minister will ultimately endeavour to correct some of the initial mistakes, and it is possible that he will take the chiropody profession more into his confidence. Time alone will show this. In the meantime, my American friends, watch us closely—to be forewarned is to be forearmed. The introduction of a National Health Service in America would not necessarily be a chiropodists' paradise.

I hope to be among you in the spring of this year and to visit New York, Philadelphia, Cincinnati, Toledo, Cleveland, Columbus and Pittsburgh. I shall be visiting the Region 3 Conclave and, I hope, the Ohio State Convention at Cincinnati. An invitation to visit the College of Chiropody at Cleveland to give a group of lectures has been gratefully accepted, and I hope to visit my very good friends, Drs. Shapiro, Pomerantz, Egerter and Collins. Dr. Collins, by the way, is visiting Britain in September where he has received several invitations to visit schools and branches of the Society of Chiropodists. The President, Mr. John R. Hall, F.Ch.S., has extended an invitation to Dr. Collins to attend the Society's conference which will be held at one of our historic cathedral cities, Norwich, from September 15th to 17th.

I have done my best to act as liaison officer for our previous American visitors and I shall be equally delighted to perform this duty for Dr. Collins and any subsequent visitors when requested to do so. It is difficult to convey to you the enormous benefit to mutual understanding and good will that the recent visits of our American colleagues have already achieved and I trust my visits to your great country are also making their own modest contribution.

Reference has been made to the shortage of chiropodists in this country but the shortage referred to was the temporary one of meeting the Minister of Health's requirements from the limited register of those complying with the 1954 regulations. We have at least another two to three thousand practitioners who are members of the approved organizations who will become available when the State Register comes into operation. There will also be a considerable additional number from the army of other persons who claim to practice chiropody who will qualify under conditions yet to be determined.

The situation will be very fluid for some time until the position is finally clarified.

All this should prove very instructive indeed to the state societies in America and, ultimately, the National Body when a national form of chiropody service is mooted, either as an individual service or as part of a general national health service.

"Censure is the price a man pays to the public for being eminent."

Benjamin Franklin

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

ALABAMA

The Alabama Association of Podiatrists-Chiropodists held its twenty-first annual meeting in Montgomery on April 9th and 10th. Proposed legislation to advance the scope of the podiatrist in Alabama was discussed. The following officers were elected: President, John G. Veres, Jr., of Montgomery; Secretary-Treasurer, Edward E. Sealy of Montgomery; Delegate, Edward E. Sealy; Alternate, E. J. Favenesi of Florence. State Board members are G. B. Crowley, Secretary; C. L. Miller and E. J. Favenesi. Legislative Committee, Stanley Frank, Chairman; C. L. Miller, G. E. Clark and E. J. Favenesi.

CALIFORNIA

Western Podiatry Congress

The largest meeting west of the Mississippi will take place in Long Beach, California, May 27, 28, 1960. Hosts will be the Harbor-Orange Division of the California Podiatry Association. The meeting is planned to provide a vacation and opportunity to relax by participating in a comprehensive scientific program. Subjects covered range from human relations for the podiatrist, success for the podiatrist in 1960, forefoot restorations, modern management of podomycosis, foot surgery and anesthesia, through the art of podiatry practice, to be delivered by such national figures as Drs. Marvin Shapiro, Robert Shor, Raymond Locke, Gordon Tobin, William Eads and Charles M. Simmons.

The Western Division of the American College of Foot Surgeons will meet on May 29th. The Women's Auxiliary of the California Podiatry Association has planned an exciting program for the wives.

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

WOMEN'S AUXILIARY
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(National Association of Chiropodists)
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SEE THE EXHIBIT AT YOUR REGION CONVENTION

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THE CALIFORNIA

PODIATRY HOSPITAL

THE FIRST OF ITS KIND IN THE WORLD . . . DEDICATED APRIL 30, 1960 . . .

The first foot surgery hospital built in conjunction with an established and well-known institution of higher learning — The California Podiatry College, founded in 1914. — The first non-profit foot surgery hospital to be built by podiatrists with the majority of monies pledged by the profession itself.

THE CALIFORNIA PODIATRY HOSPITAL will serve more than 1500 in-patients yearly from throughout the country for major and minor foot surgery. In addition it will operate in conjunction with the College Foot Clinic in the treatment of the needy and under-privileged. The College Foot Clinic has provided 500,000 instances of service in its 46 year history.

FACILITIES AT THE NEW HOSPITAL . . . 14 beds in six comfortable rooms; two major surgeries, one with an observation gallery; the latest diagnostic and X-ray laboratory equipment; a modern dietary kitchen; elevator; air conditioning — everything designed for patient comfort. The staff will consist of members of the American Podiatry Association with operating privileges extended to physicians and surgeons. Post-graduate seminars will be conducted at the hospital on a year around basis and a limited number of internships and residencies will be available.

YOUR HELP IS NEEDED . . . costs of building the hospital total approximately $350,000. Pledges are coming in each day — however, a great deal more money is needed to provide adequate facilities for the increasing number of persons requiring surgical foot care. The profession is invited to participate in the hospital's building fund.

Send all contributions to:

CALIFORNIA PODIATRY COLLEGE and HOSPITAL FUND
19 FARREN STREET
SAN FRANCISCO 15, CALIFORNIA

ILLINOIS

Zone Three

At the March meeting of the Illinois Podiatry Society's Zone Three, Dr. Conrad Dahl lectured on "Shoe Therapy Corrective Measures." Zone Three officers elected were: President, Robert D. Shaw, Galesburg; Vice President, James T. Lehman, Galesburg; Secretary-Treasurer, John R. Graham, Decatur; Scientific Chairman Alva J. Harler, Galesburg; Sergeant-at-Arms, Frank W. Siebert, Springfield.

Sangamon County Podiatry Society

On April 11th, the Sangamon County Podiatry Society installed the following officers: President, Paul F. Mahaffey; Vice President, Russell G. Hill; Secretary, Frank W. Siebert; Treasurer, Theodore M. Andreasen; Scientific Chairman, Robert R. Parker.

MINNESOTA

The state-wide March Quarterly Meeting was managed by Dr. David O'Connor and Edward Chrencik at the St. Paul Hotel. The theme was "Practice Management," and the principal speaker, Dr. F. R. Kushner, Chairman, Committee on Practice Management, The American Optometric Association.

The May quarterly meeting will be conducted by Drs. Keith Jorgenson and Harry Merrill. Dr. Jorgenson will present Dr. Ganley of Philadelphia, Pa., lecturing on the subjects of surgery and podopediatrics.

Plans were completed by Dr. Fred Conti for 11 Minnesota podiatrists to participate in a 3-day career festival at St. Thomas College in St. Paul. The Minnesota Academy of Foot Surgeons was addressed as a study group by Dr. Jack Kohl, Chicago, Illinois, Secretary of the American College of Foot Surgeons on basic principles of podiatric surgery. Dr. Don Peterson was re-elected president of the surgery study group.

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A solution of chloranil (fungicide) in a high grade nail lacquer. The lacquer holds the fungicide on to the nail so that close and intimate contact is assured.

Keralac is cosmetically elegant and when dry has the smooth and shiny surface of a nail lacquer. Further, the painting of a nail with a lacquer is appealing to the patient.

In the office, remove the infected portion of the nail and debride the nail bed. Instruct the patient to carry out the following twice a week:—1. remove old lacquer by nail polish remover; 2. sand the nail down as much as possible; 3. repaint with Keralac.

Available ½ oz. bottles complete with brush applicator.

Samples and literature on request.

SALEM PHARMACEUTICALS **Naugatuck, Connecticut**

PENNSYLVANIA

Northwestern Division

A meeting of the Northwestern Division of the Chiropody Society of Pennsylvania was held Sunday, March 6, 1960, at the Exchange Hotel in Franklin. Principal speakers at the meeting were Richard Hess, Executive Secretary of the Chiropody Society of Pennsylvania; Dr. Joseph Fletcher, President-Elect of the Chiropody Society of Pennsylvania, and Dr. Ralph Orr, President of the State Chiropody Board. Mr. Hess outlined the duties of his office and told of his plans. Dr. Fletcher detailed plans for his year as state president, stressing progress for our profession and economy of operation. Dr. Orr told the members of recent events of the State Board.

The following division officers were elected for the coming year: President, Quinton Crawford; Vice President, Richard Wagner; Treasurer, John Ziegler; Secretary, John Pankratz; Division Council, Paul Curtis, Margaret Holsapfel, Lynn Wygant; Delegates, Ted Huels and Chester Rossi; Alternate Delegates, Quinton Crawford and Richard Wagner. President Crawford made the following committee appointments: Scientific, Leo Lacey; Public Education, Chester Rossi; Sick, John McCandless; Vocational Guidance, Roger Longwell; Legislative, Ted Huels; Grievance, Leonard Pleban; Membership, John Reyer; Insurance, Dawn Russell; Hospital Relations, Earl Curtis.

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Region 8

[Va., W.Va., N.C., S.C., D.C.]

American Podiatry Association

Announces its Annual Scientific Meeting

to be held

November 11, 12, 13, 1960

Shoreham Hotel, Washington, D. C.

We extend a cordial invitation to all members of the American Podiatry Association to attend and participate.

Edward Ganny, D.S.C.

President, Region 8
American Podiatry Association

Pennsylvania Foot Health Week

Pennsylvania's Governor David L. Lawrence is pictured above signing a proclamation designating May 13 through May 20th as Pennsylvania Foot Health Week. The proclamation urged the citizens of Pennsylvania to devote their time and energies to the practice of foot hygiene during the week.

Looking on are, left, Richard C. Hess, Executive Secretary of the Chiropody Society of Pennsylvania, endorser of the week, and right, Dr. Jack S. Pincus, Pennsylvania Foot Health Week Chairman.

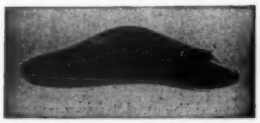
APPOINTMENT

Dr. Andrew S. Anastasio has been appointed to a 5-year term as Commissioner to the Board of Health by Mayor Richard C. Lee in the city of New Haven, replacing a local physician. This has been the first appointment of a podiatrist to the Health Commission in the history of Connecticut.

CHANGE OF ADDRESS

If you change your address please notify THE JOURNAL at least six weeks before the change is made. Include the address clipped from the envelope of your latest copy of THE JOURNAL being sure to clearly state both your old and new address. If your city has Postal Zone Numbers, be sure to include this Zone Number in your new address.

THE HOUSE OF COMFORT



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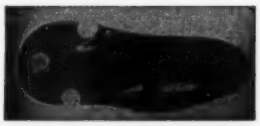


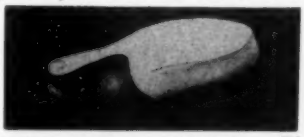
Their outstanding, skilled craftsmanship in the appliance of old-fashion and modern hand-made foot appliances for any kinds of deformity as well as Balance Inlays, Levy and Sansone Molds, Celastic, and arches of oak sole leather with blue tempered steel springs; also flexible type of supports of cork and rubber.

We also construct any type of stainless steel plates.

The priceless knowledge and experience which we learned and inherited from our fathers enable us to be very proud of our scores of years in orthopaedic work.

Every appliance constructed in our laboratory is hand made. We DO NOT HAVE ANY STOCK APPLIANCES OF ANY KIND.

It is our proud privilege to serve you and the profession in your every need and we look forward to hearing from you in the near future. Write for our literature.



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WOMEN'S AUXILIARY MESSAGE

It was my privilege to attend the Zone Six meeting in Omaha, Nebr.

The theme of the entire program was "Youth Fitness." We were most fortunate to have Dr. Shane McCarthy, Executive Director of the President's Council on Youth Fitness, speak to us. He came directly to Omaha from the White House Conference on Youth. As you know, our profession has played an important part in the Youth Fitness program.

The White House Conference on Children and Youth will probably have a tremendous impact on the manner in which America proceeds in the solution of problems surrounding the youth in this country. It is safe to predict that whatever comes out of the conference will only accentuate the great need for adult education. Inevitably adults must learn more about the needs of youth and about the maze of environmental problems surrounding their activities if they are to be helpful in their solution.

Naturally we are interested in the health of our youth, especially their feet. Probably no better service could be rendered to children and youth than for us to redouble our efforts on informing the public about Podiatry-Chiropody.

Have you shown Little Johnny Sorefoot to a group in your area?

MRS. CLEOTHA PARHAM

troubled toes! . . . give them a chance to breathe . . .

Only Baltor Bracelet (Patent 2471997)

LETS THE TOES BREATHE . . .

Slipped over the toes the bracelet creates a wider spread allowing free circulation of air to promote healing and dry "weeping" areas.

It will help to stimulate the flow of blood and help to prevent numbness of the toes.

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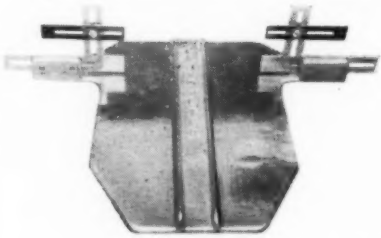
PRONOMETER



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Provides an effective and accurate means of determining and recording pronation or supination, thus eliminating guesswork and providing data showing the postural status of the foot.

The principle of measurement employed is described by Kendall and Fishman, utilizing the lateral malleolus and outer border of the calcaneus, as points at which pronation and supination are best noted and measured.

For descriptive literature write:

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RESEARCH AND DEVELOPMENT IN THE ARMED FORCES

Our Medical Service Corps podiatrists have been asked to serve with a joint service research team on footwear. This team consists of quartermaster and medical officers from the Army, Navy and Marine Corps. A podiatrist will be assigned to this project.

PODIATRY POSITIONS OPEN IN ARMY MEDICAL SERVICE CORPS

The Army Medical Service Corps has established new billets for commissioned podiatrists at some new stations. This means that there are openings for more podiatrists to be commissioned in the Army Medical Service Corps beginning June 1, 1960. Interested podiatrists-chiropodists are encouraged to make application now.

Potential applicants should contact their local Army Procurement Officer, who will supply details. We have been advised that competition for these spaces will be keen.

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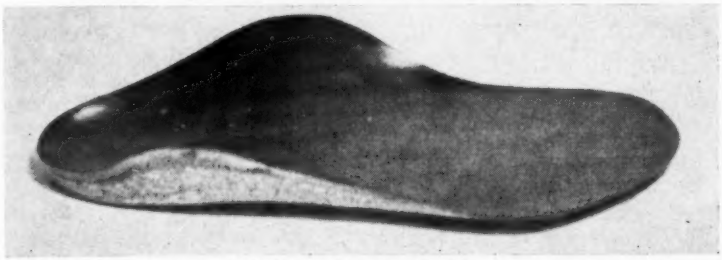

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STYLE #423—Semiflexible—Molded leather shell. Same as #2423, but without cork on bottom.

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LEGAL AND LEGISLATIVE

MICHIGAN

The Attorney General of the state of Michigan has rendered an opinion that, " . . . chiropodists may properly be considered physicians and surgeons within the meaning and scope of Act 115, PA 1915, as amended: that is to say, they are physicians and surgeons for the purpose of examining, diagnosing and treating abnormal nails, superficial excrescenses occurring on the hands and feet, including corns, warts, callosities, bunions and arch troubles, or the treatment medically, surgically, mechanically or by physiotherapy of ailments of the human foot. Obviously, the term 'licensed chiropodist' is not synonymous with 'licensed physician and surgeon' for all intents and purposes . . . "

It is anticipated that this will require most health insurance contracts to recognize claims for scheduled services when performed by a podiatrist-chiropodist.

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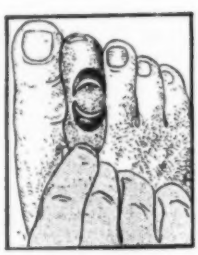
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DEATHS REPORTED

Charles Edwards
Birmingham, Alabama

Sydney G. Cohen
Philadelphia, Pa.

Dr. Cohen, a former resident of Philadelphia, passed away on March 19, 1960. She graduated from Temple University in 1939.

Mark Bailey
New York, N. Y.

W. A. Frizell
Bronx, N. Y.

Wisdom is the principal thing; therefore get wisdom. And with all thy getting, get understanding.

Proverb 4:7

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CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Chicago, Ill., Aug. 27-30, 1960
Drake Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Hartford, Conn., Oct. 21-23, 1960
Statler Hilton Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
Cincinnati, Ohio, May 19-21, 1960
Sheraton-Gibson Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood,
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Sun Valley, Idaho, Sept. 7-11, 1960
Challenger Inn
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Washington, D. C., Nov. 11-13, 1960
Shoreham Hotel
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Jacksonville, Fla., June 9-11, 1960
Robert Meyer Hotel
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Atlanta, Ga., Oct. 7-9, 1960
Dinkler Plaza Hotel
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E., Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Oklahoma City, Okla., June 20-23, 1960
Skirvin Hotel
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Western Podiatry Congress
Long Beach, Calif., May 27-28, 1960
Lafayette Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

American Academy of Chiropodists
Canadian Podiatry Association
Joint Meeting
Toronto, Ontario, Canada, Oct. 23-24, 1960
Royal York Hotel
Dr. Charles E. Kelley
2488 Lee Rd., Cleveland Heights, Ohio
Dr. L. Hurwitz
3017 Bathurst St., Toronto, Ont., Can.

Chiropody Society of West Virginia
Parkersburg, W. Va., June 10-12, 1960
Chancellor Hotel
Malcolm P. Iams, Chairman
716 Juliana St., Parkersburg, W. Va.

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STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

IN AUGUST 1960

IN CHICAGO, ILLINOIS

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A.O.P.

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———

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Bathroom News

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———

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———

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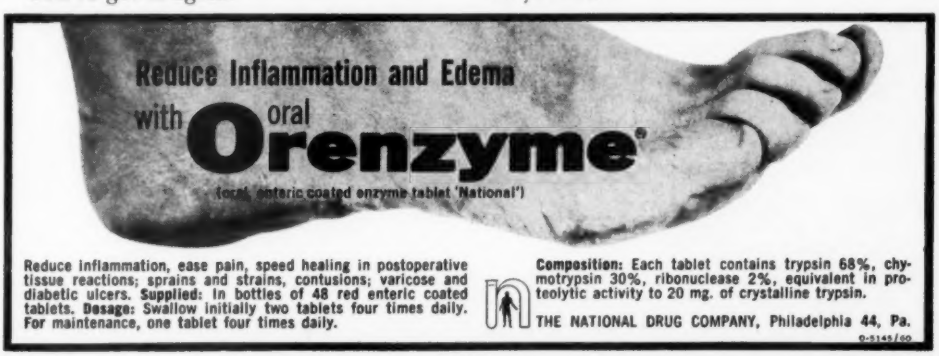

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